Eline Funeral Home Hampstead, Md

|             | 90 | her it is    |  |       | n of |  |
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|  | 1             | 12231   | DIVISION OF VITAL RECORDS,   | 201 W DESTAN STREET B  |   |   |
|--|---------------|---|--|--|---|---|
| 2  | I             | teml5 FilmC410  |  | CERTIFICATE OF DEAT  |   | 02227   |
| . 2 · i.   | 1. DI         | CEASED-NAME First   |  | Lost   | 20. DATE OF DEATH   | 2b. HOUR  |
| eral<br>and<br>deat  | (1            | ype or print)   | icie GREGOT  | RV AND Prs   | Freh Month 13   | Pay 1960 11:30  |
| fiter of fun es 1 iffer of fun es 1  | 3. SE         |   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (In years last birthday)   | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |
| rrs a<br>Page  | 1             | CMAIC   | 71 CITIZEN OF WHAT COUNTDYS  | 6/20/  | 9. COUNTY OF DEATH  | S.  |
| f hau<br>in b<br>ers.<br>"2 hau  | cau           | SIRTHPLACE (Stote or foreign atry)                            | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED NEVER MARRIED WIDOWED DIVORCED  | Carroll   | Mo  |
| sin 24<br>filled<br>pap<br>thin 7  | 10. (         | ITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL OR INS  | STITUTION (If not in hospital 12a.   | USUAL OCCUPATION (Kind of work daning most of working life, even if retired | e 12b. KIND OF BUSINESS OR INDUSTRY                     |
| rely with bon with   | 1             | 1 ANCHESTE  | Nursin   | 1 to MP  | 1 touseure  | OWN HOME  |
| executed within 24 haurs after death de completely filled in by the funeral smave carbon papers. Pages I and 3 any event, within 72 haurs after death  | odm           | ssian) STATE  | sed lived, if institution: Residence before                            | 13c. CITY OR TOWN 13d. INSIDE YES WES LA   | NO 201 MAI  | ist-  |
| d co   | 14.           | ATHER'S NAME First  | Middle Last  | IS. MOTHER'S MAIDEN NA   | ME First Middle   | Lost  |
| d in g   |               | WM.   | R. Gregor  | Y NANNIE   | Haskins   | - BUBBL   |
| an a   |               | WAS DECEASED EVER IN U.S. AR es, no, or unknown) (If yes give | 1                                | NO. 17. INFORMANT Jerri  | e Earle anders Address  | 1 111111  |
| phy<br>en<br>aval  |               | not   | 2/6-60-9   | 7046 208 Main  | St Near WING  | APPROXIMATE INTERVAL                                    |
| ing ing  |               | 18. CAUSE OF DEATH (Enter o<br>PART I. DEATH WAS CAUS         | nly one couse per line for (a), (b), and (c).                          | 0. /   | and t   | BETWEEN ONSET AND DEATH                                 |
| dea<br>Henc<br>rmit  |               |   | ATE CAUSE (0)  | examinar u   | ceceon  | ZMON  |
| the are a atiar  |               | Canditions, if ony, which gave                                | DUE TO, OR AS A CONSEQUENCE OF   | Generalis of   | artomordon  | 5 y -   |
| that<br>in.<br>by th<br>ansi   | 12            | rise to immediate cause (a),<br>stating the underlying couse  | (b)  | The state of the s | 0.0000000000000000000000000000000000000                                     |   |
| res<br>sicio<br>ned l<br>ial-ti  |               | last.   | (c)  |  |   |   |
| he law requires the attending physician. has been signed by e as the burial-train hariar ta burial, cre  |               | PART 2. OTHER SIGNIFICANT CO                                  | NDITIONS CONTRIBUTING TO DEATH BUT N                                   | OT RELATED TO THE TERMINAL DISEASI   | E OR CONDITION GIVEN IN PART 1(a)   |   |
| law<br>ndin<br>beer<br>s the   | MILION        | - 19a. DATE OF OPERATION 19b                                  | CONDITION FOR WHICH OPERATION WAS PE                                   | RFORMED 20a. AUTOPSY?  | 20b. IF YES, WERE FINDING   | S CONSIDERED IN CERTIFYING                              |
| The atternation of the property of the propert | CERTIFICATION |   |  | YES N  | CAUSES OF DEATH?  |   |
| AN:<br>Il ar<br>cate<br>ar u   |               | 21 a. ACCIDENT WAS UNDERLY!                                   |  |  | (Enter noture of injury in Port 1 ar Port                                   | 2, Item 18.)  |
| SICL<br>spirtd<br>ertiffi<br>ed f<br>ed f  | MEDICAL       | (If either, natify medical exam                               | iner) P.M.   | 9  |   |   |
| O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death Page 4 may be retained by the haspital ar attending physician.  O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages I and shauld be filled with the State Dept. at Health priar ta burial, crematian, or remaval, and in any event, within 72 haurs after death   | 2             | 21d. INJURY OCCURRED 21e While Not while at work at wark      | . PLACE OF INJURY (AT HOME, FARM, STREET, FAI<br>OFFICE BUILDING, ETC. | CTORY.) 21f. LOCATION Street or R.F.   | D. No. City ar Tawn   | Caunty State  |
| TENDING<br>ned by the<br>OR: After<br>auld be d<br>the State   |               | 22a. I certify that (1) (t                                    | nis haspital) attended the deceas                                      | ed fram 12/17 ,  | 1968, to fres 17,   | 19 <u>69</u> , that (1) (we) las                        |
| NE. A  |               | causes stated above   | e(1) (we) (did) (did nat) view the                                     | bady after death.  | ) apinian aearn accurrea an rne   | date and naur and tram the                              |
| OR ATTENT be retained DIRECTOR: A je 3 shauld ed with the  |               | 22b. SIGNATURE  | 11 11  | ATTENDING -  | MED. STAFF  | 2c. DATE SIGNED   |
| be DIR   |               | CO ! CINCICIANIC  | Trousa M   | O DEGREE PHYS.   | DIRECTOR L PHYS. L  | 2/17/69   |
| Page 4 may be retained by the h<br>Page 4 may be retained by the h<br>TO FUNERAL DIRECTOR: After this<br>directar, page 3 shauld be detac<br>shauld be filed with the State De   |               | 22d. PHYSICIAN'S<br>NAME (Type)                               | HFOARD M   | D 22e. ADDRESS 2   | so Main St<br>rehester  | 11 21102  |
| HOS<br>nge /<br>FUN<br>rect  | 230.          | BURIAL, CREMATION, 23b.                                       | DATE 23c. NAME OF  | CEMETERY OR CREMATORY  | 23d. LOCATION (City or Town)  | (County) (State)  |
| 5 5 5 2 ×  | 24            | SURIJE  | 2/20/169 METH<br>ADDRESS   | to DIST  | C'D BY REGISTRAR 2Sb. REGISTRA  | D'S SIGNATURE   |
| VR A13 (M)   | 24.           | TUNERAY DIRECTOR  | Latera Marchille   | idow Md DATEF  | 0000  | men Judga   |
| 1130   | 120           | W. Jam. 1941  | I we have well   | WWW JIW DAIE!  | LO M O 1000   | 4 8   |

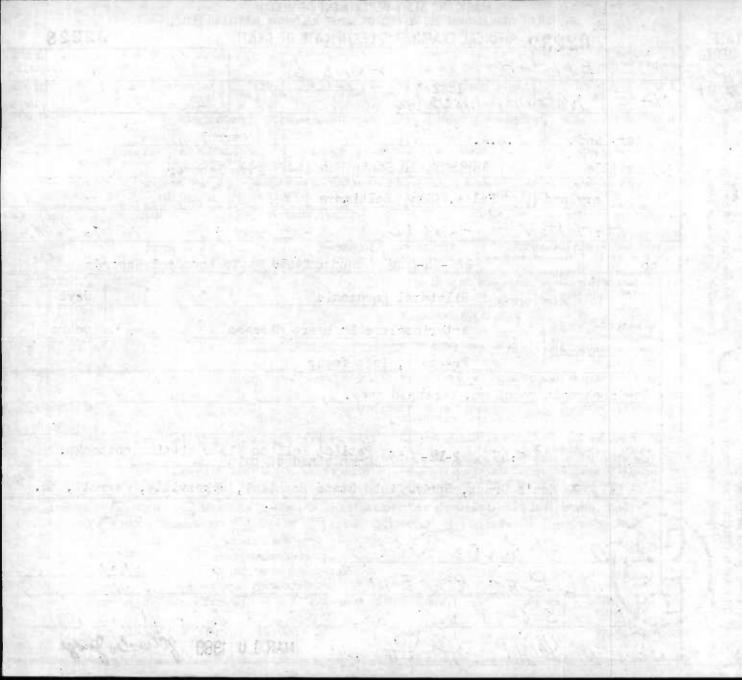
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|  | Item5 FilmGilo MARYLAND STATE DEPARTMENT OF HEALTH  |                           |
|--|---|---------------------------|
| FOR STATE  | 3/14/69 kk DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  MEDICAL EXAMINER'S CERTIFICATE OF DEATH   | 2228                      |
| HEALTH DEPT/   |   | Yeor 2b. HOUR             |
| v 0 0 X X  | (Type or Print) E11JAh ARNO/d OF ESTI- FEA 21   | 1 1969 7.35 p             |
| elay i   | 3. SEX 4. RACE 5. DATE OF BIRTH 1882 6. AGE (In years If UNDER 1 YEAR IF UNDER 24 HRS. 2c. DATE PRONOUNCED DEAD MONTHS DAYS HOURS MIN. MORE DAY   | Yeor 2d. HOUR             |
| PEWA   | 11512 White MAY 11,180/7 86 YRS.   Fet 21   | 1969 7347 N               |
| 1, 2<br>m<br>Dep   | 76. BIRTHPLACE (Stote or foreign   76. CITIZEN OF WHAT COUNTRY?   8. MARRIED NEVER MARRIED 9. COUNTY OF DEATH COUNTRY)  |                           |
| State  | Maryland U.S.A. WIDOWED DIVORCED Carroll  10. CITY OR TOWN OF DEATH  11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol 120. USUAL OCCUPATION (Kind of work done 12b. 12b. 12b. 12b. 12b. 12b. 12b. 12b. | KIND OF BUSINESS OR       |
| after death 8. Give Pages 1, altong with form with the State Du  | Sykesville give street odderstield State Hospital during most of working life, even if retired.) INDUS  |                           |
| after de along with the death.   | 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before 13c. CITY OR TOWN 13d. INSIGE CITY LIMITS? 13e. STREET AND NUMBER  |                           |
| 0 8 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5  | odmission) STATMaryland 36. COUNBalto. City Baltimore YES NO unknown  |                           |
| in within 24 hours in pencil in Item 1. Examiner's Office File pages 1 and 2. The pages 2 | 14. FATHER'S NAME First Middle ARNOLD IS. MOTHER'S MAIDEN NAME First Middle ST  | AllINGS                   |
| hin 24<br>ncil in<br>niner's<br>pages<br>haurs   | 160. WAS DECEASED EVER IN U.S. ARMED FORCES?  (Yes, no, or unknown) (If yes give wor or dates of service)  16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS   |                           |
|  | no   220-54-6645   Springfield State Hospital Record  | S<br>APPROXIMATE INTERVAL |
|  |   | BETWEEN ONSET AND GEATH   |
| ding<br>ding<br>Nedic  | IMMEDIATE CAUSE (o) DITA CETAT PRECUNIONIA  | days                      |
| e execute pending" ef Medical sit permit   | Conditions, if ony, which gove )  Out TO, OR AS A CONSEQUENCE OF  Conditions, if ony, which gove )  Arteriosclerotic heart disease  | vears                     |
| Id b<br>rd rd<br>Chi   | rise to immediate couse (a).  Stating the underlying couse (b) AT GOTTO SEQUENCE OF   | Joan                      |
| s certificate shauld be executed with your ward "pending" in pe farwarded to the Chief Medical Exarused as a burial-transit permit. File emoval, and in any event within 72  | lost. (c) Fracture, left femur  |                           |
| athe g the ed ta   | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(0)  |                           |
| ifica<br>iting<br>ardec<br>al, a   | Schizophrenic reaction, paranoid type.  |                           |
| certif<br>arwan<br>used used   | 196. CONDITION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  | 2D. AUTOPSY?              |
| be st  |   | YES NO                    |
|  | 210. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING 5 145 P.M. 2-14- 1969 21d. INJURY OCCURRED 21e. PLACE OF INJURY (At home, form, street, 21f. LOČATION Street or R.F.D. No. City or Town Course                | cks.                      |
|  | 21d. INJURY OCCURRED  21e. PLACE OF INJURY (At home, form, street, 21f. LOCATION Street or R.F.D. No. City or Town Cot  | unty Stote                |
| examute the sign of the sign o | while Not while Men's Group, Springfield State Hospital, Sykesville, Carro  |                           |
| CAL Executor. Page 1 far a cross of far a cross of burial,   |   | and in my apiniar         |
| ITY blease ery, please ery ard director. be retained RAL DIRECTO prior to bu   | death resulted from: Natural couses , Accident , Suicide , Homicide , Undetermined monner   |                           |
| ITY blease yy, please eral direct be retained RAL DIRECT Prior to be prior to b  | ACTUAL CHIEF MEDICAL EXAMINER 22b, DATE SIGNE   |                           |
| UTY,<br>beroller<br>RAL  | SIGNATURE TO STORY MEDICAL TRANSPORT 2/23/6   |                           |
| o DEPUTY SICAL EXAM necessary, please execute the funeral director. Page 4 5 may be retained far your o FUNERAL DIRECTOR: Page Health prior to buriol, crem  | EXAMINER'S M.C. PORTER FIELD ADDRESS (ALTON LEVEL FOR DEPORT OF COUNTY) FOR MICH.   | <i>p</i>                  |
| To I   | 230. BURIAL CREMATION, 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Cour  | nty) (Stote)              |
|  | 24. FUNERAL DIRECTOR ADDRESS 256/ REC'D BY REGISTRAR 256 REGISTRARS SIGNAL  | TILDE                     |
| VR A15ME (5)<br>10M REV. 1/68  | Harry W. Haight Sykipielle Md. MAR 10 1969 Jolianles &  | noge                      |
|  | 21784   |                           |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death.

Page 4 may be retained by the hospital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 shauld be filed with the State Dept. of Health priar to burial, crematian, ar remaval, and in any event, within 72 haurs after death.

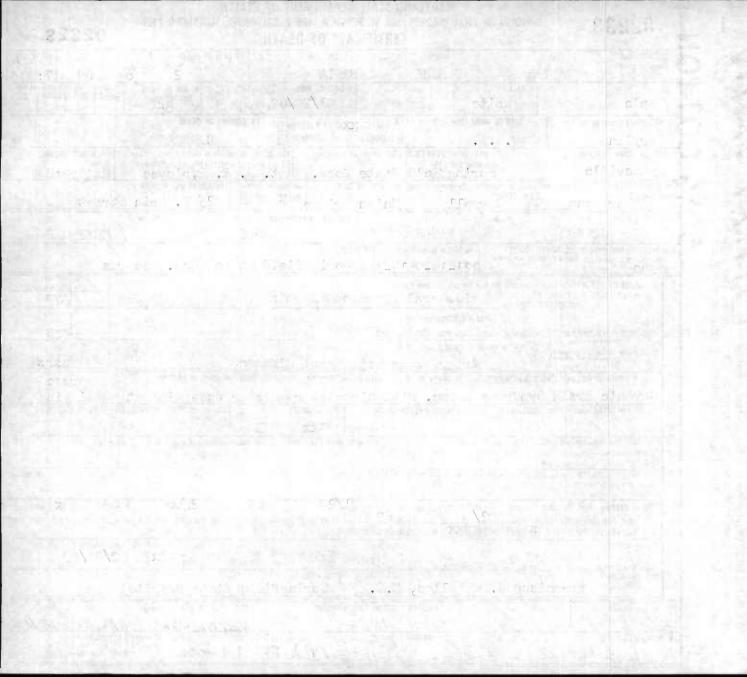
VR A15 (3)

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02229

|               | ECEASED-NAME   | First                      |  | Middle   |                 | Lost                             |                                 | 20. DATE OF     |  | 200     |                                    | 2b. HOUR                                 |
|---------------|--|----------------------------|--|--|-----------------|----------------------------------|---------------------------------|-----------------|--|---------|------------------------------------|--|
| (1            | Type or print)   | WALTE                      | R  | BLAINE   |                 | BAILE                            |                                 |                 | Month  | Day     | Year<br>69                         | 7:00                                     |
| 3. SE         | x<br>Male  |                            | 4. RACE<br>Whit                              | e  |                 | S. DATE OF BI                    | 18TH JUN 20/69 15               | E 6,            | 6. AGE (In years<br>last birthgay)                     | MON     | UNDER 1 YEAR<br>NTHS DAYS          | IF UNDER 24 HRS.<br>HOURS MIN.           |
| caun          | BIRTHPLACE (State or fo<br>htry)<br>Maryland             |                            | U.S.A  |  | WIDOWED         |                                  | RCED 🗍                          |                 | ARROLL   |         |                                    | Me                                       |
| 10. C         | CITY OR TOWN OF DEAT<br>Sykesville                       |                            | give s                                       | ME OF HOSPITAL OR INS<br>treet oddress)<br>ringfield | State           | Hosp.                            | during mos                      | of working R. F | (Kind of work don<br>life, even if retired<br>imployee |         | 12b. KIND OF<br>INDUSTRY<br>Railro | BUSINESS OR                              |
| odmi          | usual residence (Whission) STATE Maryla                  |                            | lived, if institution 13b. COUNTY            | on: Residence before                                 |                 | r town<br>Bridge                 | YES NO                          | 1111            | REET AND NUMBER N. Main                                | St      | reet                               |  |
| 14. F         | FATHER'S NAME FI   | rst<br>EPH                 | Middle                                       | Lost<br>BAILE  |                 | S. MOTHER'S M                    | AIDEN NAME Firs                 |                 | Middle   | FL      | ECKING                             | Last<br>GER                              |
|               | . WAS DECEASED EVER I<br>'es, na, ar unknawn)            |                            | or dates of servicel                         | 16b. SOCIAL SECURITY N<br>721-18-961                 |                 | INFORMANT Spring                 | field S                         | State F         | Address<br>Hosp. Rec                                   | ord     |                                    |  |
|               | 18. CAUSE OF DEATH<br>PART 1. DEATH V                    | VAS CAUSED 8               | one couse per lin<br>BY:<br>CAUSE (a)        | e for (o), (b), ond (c).)<br>Bilateral               | brone           | hopneur                          | nonia                           |                 |  |         | CETWIEN OF                         | MATE INTERVAL<br>DINSET AND DEATH<br>BYS |
|               | Conditions, if any, where to immediate co                |                            | (b)  | s a consequence of<br>Heart fail                     | lure            | (A)                              |                                 |                 |  |         | d                                  | ays                                      |
|               | stating the underlyingst.                                | )                          | (c)  | Arteriose  |                 |                                  |                                 |                 |  |         | у                                  | ears                                     |
| NC            |  |                            |  | assoc. wi  |                 |                                  |                                 | turbano         | e withou   | t q     | phra<br>ualify                     | ying                                     |
| CERTIFICATION | 19a. DATE OF OPERATIO                                    | N 19b. CO                  | NDITION FOR WHI                              | CH OPERATION WAS PER                                 | RFORMED         | 2Da. AUTO                        |                                 |                 | YES, WERE FINDING<br>OF DEATH?                         | s consi | DERED IN CE                        | ERTIFYING                                |
| MEDICAL CE    | 21o. ACCIDENT WAS ON CONTRIBUTING (If either, natify med | AUSE OF DEATH              |  | INJURY<br>Manth Day Year                             |                 | IOW INJURY OCC                   | CURRED (Enter 1                 | noture af injur | y in Part 1 or Port                                    | 2, Item | 18.)                               |  |
|               | at wark at wark  |                            |  | AT HOME, FARM, STRFET, FAC<br>OFFICE BUILDING, ETC.  | -               |                                  |                                 |                 | ar Tawn  |         | aunty                              | Stote                                    |
|               | 22a. I certify the                                       | at (I) (this<br>eased aliv | haspital) atte<br>e an 02<br>F) (we) (did) ( | nded the decease                                     | d from_9_69, ar | 01/20<br>nd that in (m<br>death. | , 19 <u>69</u><br>y) (aur) apin | ian death a     | ccurred an the   | date o  | 2_, that<br>and haur               | (1) (we) las                             |
|               | 22b. SIGNATURE   | ico (                      | Cel  | ells, m  | DEG DEG         |                                  |                                 | D.<br>RECTOR    | STAFF PHYS.  | OZ,     | SIGNED / 06/69                     | 9  |
|               | 22d. PHYSICIAN'S<br>NAME (Type)                          | //                         | sco J.                                       | Ceballos,  |                 |                                  | ringfiel                        |                 | e Hospit   | al      |                                    |  |
| B             | BURIAL, CREMATION,<br>REMOVAL (Specify)                  | 23b. DA                    | /  | 23c. NAME OF C                                       | CRE             | EK                               |                                 | NEWWI           | N (City or Town)                                       | URA     |                                    | (State)                                  |
| 24.           | FUNERAL DIRECTOR   | auth                       | Leves  | ADDRESS  | SIX             |                                  | 25a. REC'D BY                   |                 | 2Sb. REGISTRA  |         | NATURE ON                          | 109                                      |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and dempletely filled in director, page 3 should be detached far use as the burial-transit permit. Then please remove carban papers, shauld be filed with the State Dept. af Health priar to burial, crematian, ar remaval, and the any event, within 72 h

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be

Page 4 may be retained by the haspital ar attending physician.

executed within 24 haurs after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02231

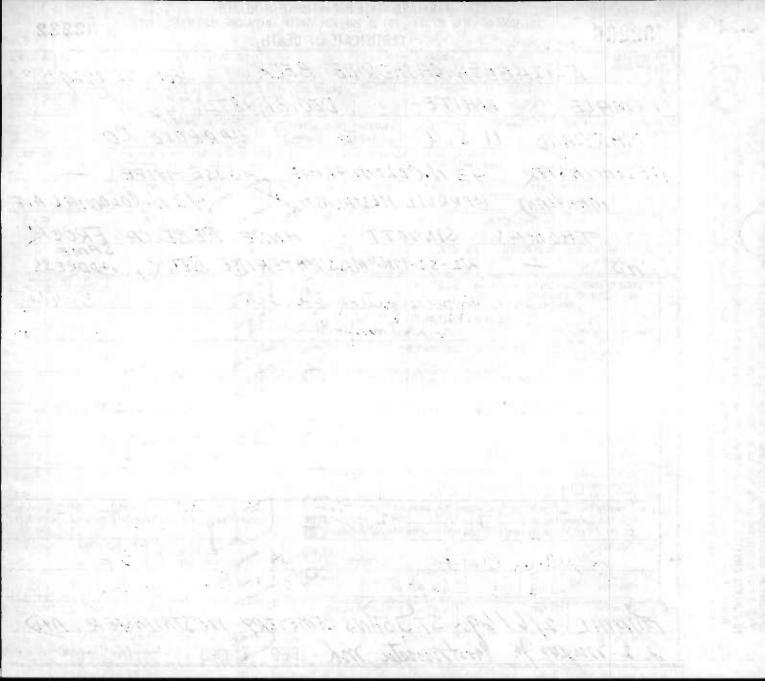
| 176600  | CEI  | RTIFICA                        | TE OF DEATH                 |                                  |  | 022                       | 0 2                                   |
|---|--|--------------------------------|-----------------------------|----------------------------------|--|---------------------------|---------------------------------------|
|   | KURT HARRY   | BANDE                          |                             |                                  | of DEATH uary North, 19                  |                           | 2b. HOUR 6:30A                        |
| 3. 5EX<br>Male  | 4. RACE White  | 5.                             | 6-14-85                     |                                  | 6. AGE (In years left) birthdoy) YR5.    | MONTHS DAYS               | HOURS MIN.                            |
| 70. BIRTHPLACE (Stote or foreign country)  Germany  10. CITY OR TOWN OF DEATH  Sykesville     |  | JTION (If not                  | in hospitol 120. USL        | 9. COUNTY  JAL OCCUPATION PORTER | Carroll ON (Kind of work done            |                           | BUSINESS OR                           |
| 13o. USUAL RESIDENCE (Where deceose odmission) STATE Maryland                                 | ed lived, if institution: Residence before 130   | altime                         |                             |                                  | STREET AND NUMBER 16 S. Fulto            |                           | 49                                    |
| 14. FATHER'S NAME First William   | Middle Lost Bandemer   |                                | MOTHER'S MAIDEN NAME Thelma | First                            | Middle                                   |                           | Lost                                  |
| 16o. WAS DECEASED EVER IN U.S. ARM<br>Yes, no, or unknown) (If yes give ye                    | ED FORCES? or or dotes of service) 212=01=3461   | _                              | ords, Sprin                 | gfield                           | State Hosp                               | ital                      |                                       |
| PART 1 DEATH WAS CALISED  | DUE TO, OR AS A CONSEQUENCE OF   |                                |                             |                                  |  |                           | MATE INTERVAL<br>ONSET AND DEATH<br>B |
| stoting the underlying couse lost.  | DUE TO, OR AS A CONSEQUENCE OF  (c) Chronic adh  DITIONS CONTRIBUTING TO DEATH BUT NOT R                         | esive                          | pericardit                  |                                  | VFN IN PART 1/o)                         | year                      | rs.                                   |
| Involutional 190. DATE OF OPERATION 195. (  | ONDITION FOR WHICH OPERATION WAS PERFOR  | RMED                           | 20o. AUTOPSY?  YES NO       | 20b.                             | IF YES, WERE FINDINGS (<br>5ES OF DEATH? |                           | ERTIFYING                             |
| 210. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examin | HOUR A.M. Month Doy Year   | 21c. HOW                       | INJURY OCCURRED (Ente       | er nature of in                  | njury in Port 1 or Port 2,               | Item 18.)                 |                                       |
| 21d. INJURY OCCURRED While Not while ot work of work  | PLACE OF INJURY ( AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.  | 21f. LOCA                      | TION Street or R.F.D. No    | 0. (                             | ity or Town                              | County                    | Stote                                 |
| 22a. I certify that (I) (thi<br>saw the deceased al<br>couses stated abave                    | s hospitol) attended the deceosed tive on 2-11-196<br>ive on 2-11-196<br>, (I) (we) (did) (did not) view the bad | rom<br>2_, and t<br>y after de | hat in (my) (our) on        | 13, to_<br>inion deat            | 2—II, 19<br>h accurred on the do         | 69_, that<br>ate and hour | (I) <u>(we)</u> last<br>and from the  |
| 22b. SIGNATURE Toesn to   | T. Dagii   | DEGREE                         | ATTENDING PHYS.             | MED.<br>DIRECTOR                 | STAFF 22c.                               | 2-11-69                   | 9                                     |
| 22d. PHYSICIAN'S<br>NAME (Typicorito  | Sagisi, M.D.   |                                | 22e. ADDRESS<br>Springfie   | ld Sta                           | te Hospital                              |                           |                                       |
| 230. BURIAL, (REMATION, REMOVAL (Specify)   |  |                                | EMATORY PARK                |                                  | TION (City or Town)                      | (County)                  | (Stote)<br>Md.                        |

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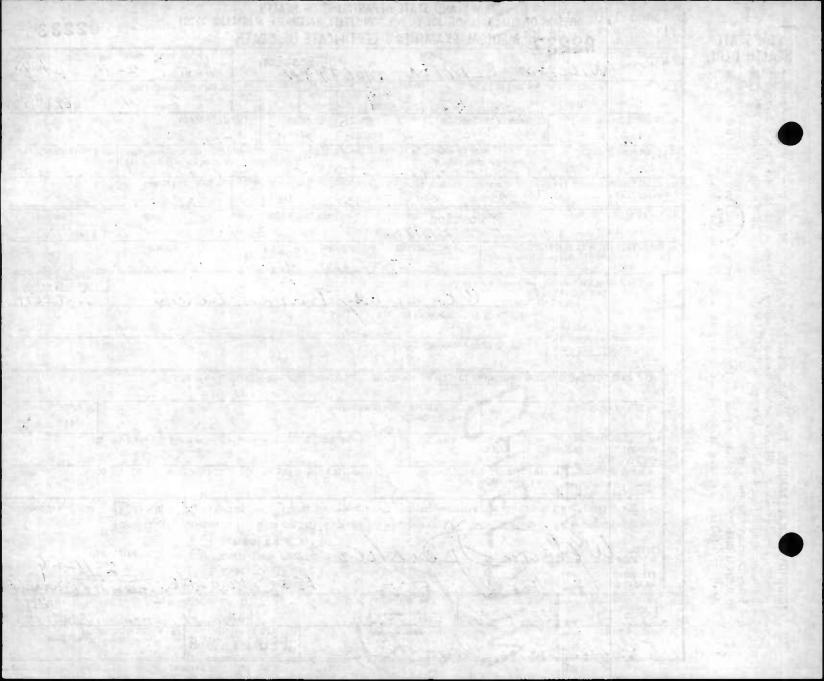
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VR A15 (4) 30M REV. 1/68



| 1  | 1 1           | MARYLAND STATE DEPARTMENT OF HEALTH  Tems 1, 14 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   |
|--|---------------|---|---|
| FOR STATE  | Fi            | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   | 02233   |
| HEALTH DEPT.   |               | PECEASED-NAME Last 2a. DATE KNOWN Month D   | Day Year 2b. HOUR                               |
| 5 4 8 g  | (             | VILLIAM CLINION 3/08/7/1/AIN DEATH MATED 1  | 11 1969 10:45                                   |
| delay<br>and a   | 3. S          | 4. RACE S. DATE OF BIRTH 6. AGE (In years 1 Funder 1 Funder 24 HRS. 2c. DATE PRONOUNCED DEAD Months DAYS HOURS MIN. 48 YRS.   | Year 1969 2d, HOUR                              |
| 2, 2, PA   | 7a.           | BIRTHPLACE (State or foreign   7b. CITIZEN OF WHAT COUNTRY?   8. MARRIED   NEVER MARRIED   9. COUNTY OF DEATH   |   |
| arm,<br>de De  | caur          | MARYLAND USA WIDOWED DIVORCED CARROLL   | M   |
| after death any of S. Give Pages 1, 2, a along with farm PM with the State Depart cath.                                      | 1D. (         |   | 2b. KIND OF BUSINESS OR                         |
| er de live mg w gg w   | 120           | VESTMINSTER  give street oddsess)  DOA  GEBORE  Give deceased lived, if institution: Residence befare 13c. CITY OR TOWN  13d. INSIDE CITY LIMITS?  13e. STREET AND NUMBER | CEMENI  |
|  |               | odmission) STAMPRYLAND 131. COUNTEREDERICK JOHNSVILLLEYES NO NONE   |   |
| 24 haurs af in Item 18. r's Office ald   | 14.           | FATHER'S NAME First Middle Bostion Last IS. MOTHER'S MAIDEN NAME First Middle   | RIMM  |
| hin 24 ncil in niner's pages haurs   | 160           | WAS DECEASED EVED IN U.S. ADMED CODESS. 144 SOCIAL SECURITY NO. 17 INSODMANT  | 1/////  |
| executed within anding" in pencil Medical Examine t permit. File pagint within 72 hau  |               | Yes, no, or unknown) (If yes give war or dates of service) 215-14-1739 LINDA BUSTIAN JOHNSVILL  |   |
| ed v<br>in l<br>in Ex<br>in Fil  |               | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| be executed<br>"pending" in<br>nief Medical E<br>ansit permit. F<br>event within   |               | IMMEDIATE CAUSE (a)   | Serdden   |
| be ex<br>"penc<br>nief M<br>nief W<br>event  |               | DUE TO, OR AS A CONSEQUENCE OF  Canditians, if any, which gave  |   |
| ould by vord " ne Chie al-tran   | 1             | rise to immediate cause (a), stating the underlying couse  (b)  DUE TO, OR AS A CONSEQUENCE OF  |   |
| e shauld be e<br>the word "per<br>ta the Chief I<br>b burial-transit<br>nd in any even                                       |               | last. (c)   |   |
| 5 d = = 5  |               | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |
| certifica<br>, writing<br>arwardec<br>used as<br>maval, a  | NOIL          | 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION   | 2D. AUTOPSY?                                    |
|  | CERTIFICATION | WAS PERFORMED?  | YES NO  |
| Th<br>ifica<br>ifica<br>ifica<br>or  |               | 210. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING 10 TO Part 1 or Part 2, Item HOUR A.M. 21c. HOW INJURY OCCURRED (Enter noture af injury in Part 1 or Part 2, Item         | n 18.)  |
| ilNER: Time certifice should by files. 3 should boatian, or  | MEDICAL       | CAUSE OF DEATH P.M. 19  | County State                                    |
| =  | >             | 21d. INJURY OCCURRED  21e. PLACE OF INJURY (At home, farm, street, factory, affice building, etc.)  21f. LOCATION Street or R.F.D. No.  City or Town                      | Coomy   |
|  |               | 22a. I certify that I taak charge of the remains described above, held an Autopsy , Inspection , Inquiry ,  | and in my apiniar                               |
| ICAL E<br>e executor. Por<br>ed far<br>iCTOR: I<br>burial,   |               | death resulted fram: Natural causes Accident , Suicide , Hamicide , Undetermined manner   |   |
| olease<br>direct<br>direct<br>direct<br>DIRE   |               | ACTUAL (819) CHIEF MEDICAL EXAMINER (1) 22h DATE SI   |   |
| TY, Py, Peral Se ra SAL SAL Prior  |               | SIGNATURE AND ASSISTANT MEDICAL EXAMINER DEDUTY MEDICAL EXAMINER  | 2-11-69   |
| O DEPUTY  O DEPUTY  DICA  DECESSORY, please e  the funeral director  S may be retained  O FUNERAL DIRECT  Health priar to bu |               | EXAMINER'S NAME (Type) W GLENN SPEICHER DESSISTED STREET STATES   | ster Carrol                                     |
| 10<br>10<br>10<br>14<br>He   | 230           | PEMOVAI (Sperify)   | County) (SMC)                                   |
|  | 24            | BUKIAL 1 - 1969 11/180/151 191001EBUAGE   | CARRILL MIL                                     |
| VR A15ME (5)   | 1             | FUNERAL DIRECTOR, ADDRESS 250. RECD BY REGISTRAR 250. REGISTRAR 3511  DATE EB 17 1969   | of Judges                                       |
| 10M REV. 1/68  | LA            | 10 House Com Man Pring  |   |



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item23 FilmGl09 2/26/69 kk CERTIFICATE OF DEATH 02234 2b. HOUR am DECEASED-NAME First Middle Lost 2a. DATE OF DEATH deoth. (Type or print) Month .0:30 M Mamie Branson 3. SEX 4. RACE S. DATE OF BIRTH 6. AGE (In years PHYSICIAN: The low requires that the death certificate be executed within 24 hours aften IF UNDER 24 HRS. last birthday) 6/2/82 female Negro 7a. BIRTHPLACE (Stote or fareign 7b. CITIZEN OF WHAT COUNTRY? 9. COUNTY OF DEATH MARRIED NEVER MARRIED Maryland USA WIDOWED | DIVORCED [ Carroll 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12o. USUAL OCCUPATION (Kind of work done 12b. KIND OF BUSINESS OR give street oddress)
Springfield State Hospital during most of working life, even if retired.) INDUSTRY physician ond completely ten please remove corbony Rural--Sykesville event, 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before 13c. CITY OR TOWN 13e. STREET AND NUMBER 13d. INSIDE CITY LIMITS? odmissian) STATE COUNTY 743 McCabe Avenue Baltimore YES TX NO. and in ony 14. FATHER'S NAME First Middle Last 15. MOTHER'S MAIDEN NAME First Lost Emily Frank Thomas Branson 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT Address Yes, na, ar unknawn) (If yes give war or dates of service) 218-52-1382 Springfield Hospital records, Sykesville, Md. or remova 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY Congestive heart failure permit. hours IMMEDIATE CAUSE (o' cremation, DUE TO, OR AS A CONSEQUENCE OF signed by the burial-tronsit p days Canditions, if ony, which gave) Uremia rise ta immediate cause (o). DUE TO, OR AS A CONSEQUENCE OF stoting the underlying couse days Dehydration burial PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(g) Chronic brain attending p O FUNERAL DIRECTOR: After this certificate hos been as the syndrome associated with cerebral arteriosclerosis with behavioral reaction. 190. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING 20g. AUTOPSY? CAUSES OF DEATH? YES [ use NO DE for use by the hospital or 21o. ACCIDENT WAS UNDERLYING 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 ar Port 2, Item 1B.) 21b. TIME OF INJURY OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Manth Doy Year J O (If either, natify medical examiner) P.M. detached 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. No. City or Town State County While Not while of work 22a. I certify that \$0 (this haspital) attended the deceased from 6/26/, 19 68, ta 2/1/, 19 67, that (unique) last care the deceased glive an 2/1/, 19 69, and that in page (aur) opinion death accurred an the date and haur and from the be retained should causes stated abave, 11) (we) (did) (2006t) view the bady after degath. 22c. DATE SIGNED ATTENDING 2/7/69 DIRECTOR director, poge 3 PHYS. Springfield State Hospital PHYSICIAN'S 22e. ADDRESS NAME (Type) Naci N. Buyukunsal, M. D. Sykesville, Maryland 23o. BURIAL, CREMATION 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Burial (Specify) 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 30M REV. 1/68

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MARYLAND STATE DEPARTMENT OF HEALTH 02235 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH DECEASED-NAME First Middle Last 20. DATE OF DEATH 2b. HOUR (Type ar print) Month Year William Brown 7969 Thomas 3. SEX 4. RACE S. DATE OF BIRTH IF UNDER I YEAR 6. AGE (In years last birthdoy) HOURS 8-08-89 Male White 24 hours ( ond completely filled in by the Temove carban popers. Pagany event, within 72 hours 7o. BIRTHPLACE (Stote or foreign 7b. CITIZEN OF WHAT COUNTRY? 9. COUNTY OF DEATH 8. MARRIED NEVER MARRIED country) Maryland WIDOWED TV DIVORCED | USA Carroll 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12a, USUAL OCCUPATION (Kind of work done 12b. KIND OF BUSINESS OR within during most of working life, even if retired.)

Laborer/retired give street address) INDUSTRY Springfield State Hosp. Rural Continental 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before 13c. CITY OR TOWN 13e. STREET AND NUMBER 13d INSIDE CITY LIMITS? be executed 18b. COUNTY Kol6 Edg ar Raltimore Tempoe and in any 14. FATHER'S NAME IS MOTHER'S MAIDEN NAME First Last Lost physicion c Unknown Ilnknown requires that the death certificate 16g. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT Md. (If yes give war or dates of service) Yes, no. or unknown) burial, cremation, or removal, 215-01-6523 Springfield State Hosp, records. Sykesville 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY permit. IMMEDIATE CAUSE (a) signed by the burial-transit p Conditions, if any, which gove) rise ta immediate couse (a). DUE TO, OR AS A CONSEQUENCE stating the underlying couse PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) **10 HOSPITAL OR ATTENDING PHYSICIAN:** The low re Page 4 may be retained by the hospital or attending **TO FUNERAL DIRECTOR:** After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Heelth prior to 1 19g. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES 🔲 NOT 21a. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Manth Doy Year (If either, natify medical examiner) 21d. INJURY OCCURRED ( AT HOME, FARM, STREET, FACTORY, ) 21f. LOCATION Street or R.F.D. No. 21e. PLACE OF INJURY City or Town County State While Nat while at work saw the deceased alive an 2-23-1969, and that in (my) (aur) apinion death accurred on the date and hour ond from the couses stated above, (I) (we) (did) (did not) view the bady after death. 22a. I certify that (1) (this haspital) attended the deceased from..... 22B. SIGNATURE 22c. DATE SIGNED ATTENDING STAFF DEGREE DIRECTOR 22d. PHYSICIAN'S 22e. ADDRESS NAME (Type) Gracito Patricio 23a. BURIAL CREMATION 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY (State) (County) REMOVAL (Specify) 25b. REGISTRAD'S SIGNATURE 250. REC'D BY REGISTRAR
DATE FEB 2 5 ADDRESS 1969

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FOR STATE HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burlal-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME 3500 4-64

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## MARYLAND STATE DEPARTMENT OF HEALTH 02240 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02236 DEATH MEDICAL EXAMINER'S CERTIFICATE OF

| 1. PLACE OF DEATH a. COUNTY  CARRO //  MARYLAND  | a. STATE b. COUNTY  Marvland Carroll   |
|--|--|
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                                   |
| Union Mills  | Westminster (Union Mills)  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   | d. STREET AODRESS  e. IS RESIOENCE on a farm?  |
| R # 2 Westminster, Md.   | Route # 2  |
| 3. NAME OF DECEASED (Type or print) (ASS)  | BUNCH   4. DATE OF JEATH FUT: 19 1969  |
| 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED   | 8. DATE OF BIRTH 9. AGE (In years   IFUNDER 1 YEAR   IFUNDER 24 HRS. last birthday)   Months   Days   Hours   Min. |
| Male White WIDOWEO OIVORCED  | Jan. 18.1898 71 yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?   |
| Carpenter Construction  13. FATHER'S NAME  | Tennessee U.S.A.  14. MOTHER'S MAIDEN NAME   |
| Charlie Bunch  | Enily Lou Gibson   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. (Yes, no, or unknown)   (If yes give war or dates of service)  | INFORMANT Address  |
|  | ward Bunch, Westminster, Maryland 21157  |
| 18. CAUSE OF OEATH [Enter only one cause pay line for (a), (b), and (c).]  | INTERVAL BETWEEN   |
| PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carchae   | infaction money  |
| Conditions, If any, which \ DUE TO (Interior) Sclere   | In C-V Dinesse Hus   |
| Conditions, If any, which gave rise to immediate (b)   | THE CV. ONSERVED 19  |
| cause (a), stating the OUE TO  |  |
| underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL   | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)   19. WAS AUTOPSY  |
| OF TAKE II. OF THE CONTROL OF THE CO | PERFORMED? YES NO  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL  20a. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH.   | URRED. (Enter nature of injury in Part I or Part II of Item 18.)   |
| 20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PL  | ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)  |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL fact work new p.m. 19 at work at work 19   | 0171311001,011100110151,01017  |
| 21. I certify that I took charge of the remains described above, he  | eld an Autopsy , Inspection , Inquiry , and in my opinion  |
|  | sicide , Homicide , Undetermined manner  |
| 1 0 0 1 0 1  | CHIEF MEDICAL EXAMINER   |
| SIGNATURE Dannie C. Martiell   | M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED  |
| EXAMINER'S M.C. PORTERFIESD  | Haddress (Street, City, town, or county) 12 2-19-69  |
| 23a. BURIAL, CREMATION, 23b. OATE THEREOF 23c. NAME OF CEMETER REMOVAL (Specify)   | Y OR CREMATORY 23d. LOCATION (City, town or county) (State)  |
| Burial 2/23/69 Lady Collins  | Cemetery Sneedville, Tennessee   |
| 24. FUNERAL DIRECTOR ADDRESS   | FEB 2 1 1969 CHEMICS SIGNATURE   |
| C.O.Fuss & Son Taneytown, Mar  |  |

wifth notable well-delicated The second secon nondiff on william or things TALLO-2931 Transplanted, round and, saider 21 SASSAGE CONTINUE DE PROPERTO DE SASSAGE CONTRACTOR DE CONT Tonsamuli, massesme Tonsamin most a security. 

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02241 02237 CERTIFICATE OF DEATH DECEASED-NAME First Middle Last 2a. DATE OF DEATH 2b. HOUR death. within 24 haurs after death (Type ar print) ician and samplefely filled in by the funeral lease remave carban papers. Poges 1 ond and in any event, within 72 baurs after deat EMMA B. COHEN S. DATE OF BIRTH IF UNDER 24 HRS. 3. SEX 4. RACE 6. AGE (In years IF UNDER I YEAR last birthday) NOURS FEMALE WHITE AUGUST 5. 1910 58 7a. BIRTHPLACE (State or foreign 7b. CITIZEN OF WHAT COUNTRY? 9. COUNTY OF DEATH 8. MARRIED X NEVER MARRIED CARROLL DIVORCED WIDOWED [ BALTIMORE, MD. 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in haspital 12a. USUAL OCCUPATION (Kind of work done 12b. KIND OF BUSINESS OR give street address) AT HOME during mast of warking life, eyen if retired.)
HOUSEWIFE please remave carban WESTMINISTER executed 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence befare 13c CITY OR TOWN 13e. STREET AND NUMBER 13d. INSIDE CITY LIMITS? 13b. COUNTY CARROL 33 WASHINGTON ROAD IS. MOTHER'S MAIDEN NAME First 14. FATHER'S NAME Middle Last PHYSICIAN: The law requires that the death certificate be KAMINSKY BIORSKI FANNIE JOSEPH 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT 133 WASHINGTON ROAD Yes no ar unknown) remaval, MR. LOUIS COHEN. WESTMINISTER, MD. 21157 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Canditions, if any, which gave ) signed by the burial-transit p rise to immediate cause (a), DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as the 19g, DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES 🗌 NO F far use 21a. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Month Day Year (If either, natify medical examiner) detached ( AT NOME, FARM, STREET, FACTORY, ) 21f. LOCATION Street or R.F.D. No. 21d. INJURY OCCURRED 21e. PLACE OF INJURY City or Town County State While Nat while at wark TENDING 1962 to Feb 21 1969, that (1) (we) last 22a. I certify that (1) (this haspital) attended the deceased from Dec., 1962, to Parall, 1969, that (1) (we) last saw the deceased alive an Feb. 21, 1969, and that in (my) (aur) apinian death accurred an the date and haur and from the saw the deceased alive an Fel Zi be retained shauld causes stated abave, (1) (we) (did) (did nat) view the bady after death. 22c. DATE SIGNED 22b. SIGNATURE TO HOSPITAL OR Page 4 may be re ATTENDING PHYS. DIRECTOR 22d. PHYSICA 22e. ADDRESS NAME (Type) directar, shauld b 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION 23b. DATE (Caunty) (State) BURY (Specify) MARYLAND BETH JACOB FINKSBURG. 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR BROS., 6010 REISTERSTOWN ROAD

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| A. S. Tangan   |             | SERVE HOSE.  |               | 9 2 2 2 2    | TANKS!       |
|  |             | THE STATE OF | T. STREET     |              |              |
| AND THE PARTY OF T | THE MARKET  | TENER OF     |               |              |              |
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02242 02238 CERTIFICATE OF DEATH 1 DECEASED-NAME Lost First Middle 20. DATE OF DEATH 2b. HOUR (Type or print) ENGLAR Month within 24 haurs after 3. SEX 4 RACE S. DATE OF BIRTH 6. AGE (In years lost birthdoy) NONTHS DAYS HOURS DEC 27-7a. BIRTHPLACE (State or foreign 7b. CITIZEN OF WHAT COUNTRY? 9. COUNTY OF DEATH 8. MARRIED NEVER MARRIED country) DIVORCED [ WIDOWED X ID. CITY OR TOWN OF DEATH 12o, USUAL OCCUPATION (Kind of work done 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12b. KIND OF BUSINESS OR BROOKE during most of working life, even if retired.) INDUSTRY HOUSEKEEPER 13o, USUAL RESIDENCE (Where deceased lived, if institution: Residence before 13e. STREET AND NUMBER 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? requires that the death certificate be executed 13b. COUNTY NO | YES X NONE signed by the attending physician and k burial-transit permit. Then please remo burial, crematian, ar remaval, and in am 14. FATHER'S NAME Middle Middle Lost 1S. MOTHER'S MAIDEN NAME First MYERS GEIMAN the attending physician sit permit. Then please 160. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO 17. INFORMANT Address Yes, no. or unknown) 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO, OR AS A CONSEQUENCE OF Conditions, if ony, which gove ) rise to immediate couse (a). DUE TO, OR AS A CONSEQUENCE OF be retained by the haspital or attending physician. stoting the underlying couse PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) has been etached far use as the Dept. af Health priar ta 190. DATE OF OPERATION 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20o. AUTOPSY? CAUSES OF DEATH? YES [ NO [ TO FUNERAL DIRECTOR: After this certificate 21o. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.) OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Month Doy (If either, notify medical examiner) ( AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. No. 21d INIURY OCCURRED 21e. PLACE OF INJURY Stote City or Town County While Not while of work causes stated abave, (1) (we) (did not) view the body after deoth. 22b. SIGNATUR 22c. DATE SIGNED **ATTENDING** MED. DIRECTOR STAFF PHYS. DEGREE PHYS 22d. PHYSICIAN'S NAME (Lype 22e. ADDRESS directar, po shauld be f 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION 23b. DATE NAME OF CEMETERY (County) (Stote) REMOVAL (Specify)

**ADDRESS** 

24. FUNERAL DIRECTOR

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02239 82243 CERTIFICATE OF DEATH 2a. DATE OF DEATH 2b. HOUR 1. DECEASED-NAME Middle Last First Manth Fet Day 20 (Type ar print) Year OMA 0 5 ease remove carban popers. Pages I ond in any event, within 72 hours after 4 RACE 6. AGE (In years IF LINDER 1 YEAR IF LINDER 24 HRS. S. DATE OF BIRTH 24 hours after completely filled in by the football of the fo last birthday) OAYS HOURS MONTHS white Female 2-6-188 CO YRS 9. COUNTY OF DEATH 7o. BIRTHPLACE (Stote or foreign 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED NEVER MARRIED USA carroll DIVORCED WIDOWED -12a. USUAL OCCUPATION (Kind af wark dane 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in haspital 12b. KIND OF BUSINESS OR requires that the death certificate be executed, within give street address) during mast af warking life, even if retired.) INDUSTRY 13a, USUAL RESIDENCE (Where deceased lived, if institution: Residence before 13c. CITY OR TOWN 13d INSIDE CITY LIMITS? 13e. STREET AND NUMBER admissian) STATE 13b. COUNTY NO physicion ond c 1S. MOTHER'S MAIDEN NAME First Middle 14. FATHER'S NAME Middle William 17. INFORMANT Address 16g. WAS DECEASED EVER IN U.S. ARMED FORCES? SON Yes, na, ar unknawn) (If yes give war or dates of service) remaval 46 6151 APPROXIMATE INTERVAL 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) BETWEEN ONSET AND DEAT PART I. DEATH WAS CAUSED BY: permit. 0 IMMEDIATE CAUSE (a) crematian, Canditians, if any, which gave burial-tronsit rise ta immediate cause (a), DUE TO, OR AS A CONSEQUENCE OF signed by stating the underlying cause burial PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE JERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) TO FUNERAL DIRECTOR: After this certificate has been as the 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? CAUSES OF DEATH? YES 🗀 NO TH far use by the hospital or 21a. ACCIDENT WAS UNDERLYING 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 21b. TIME OF INJURY OR CONTRIBUTING CAUSE OF CEATH HOUR A.M. Manth Day Year P.M. (If either, natify medical examiner) detached ( AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. Na. State 21d. INJURY OCCURRED 21e. PLACE OF INJURY City or Town County While Nat while at wark at wark 220. I certify that (1) this hospital attended the deceased from 196 and the ond that in (my) (our) opinion death occurred on the date and hour and from the sow the deceased glive on should (did not) view the body ofter deoth. couses stoted obove, (1) (we) (did) 22b. SIGNATURE 22c. DATE SIGNED ATTENDING DEGREE PHYS. DIRECTOR director, page should be filed 22d. PHYSICIAN'S 22e, ADDRESS NAME (Type) AMPSTEA (Stote) NAME OF CEMETERY OR CREMATORY BURIAL CREMATION 23b. DATE 23d. LOCATION (City or Town) (Caunty) EMOVAL (Specify)

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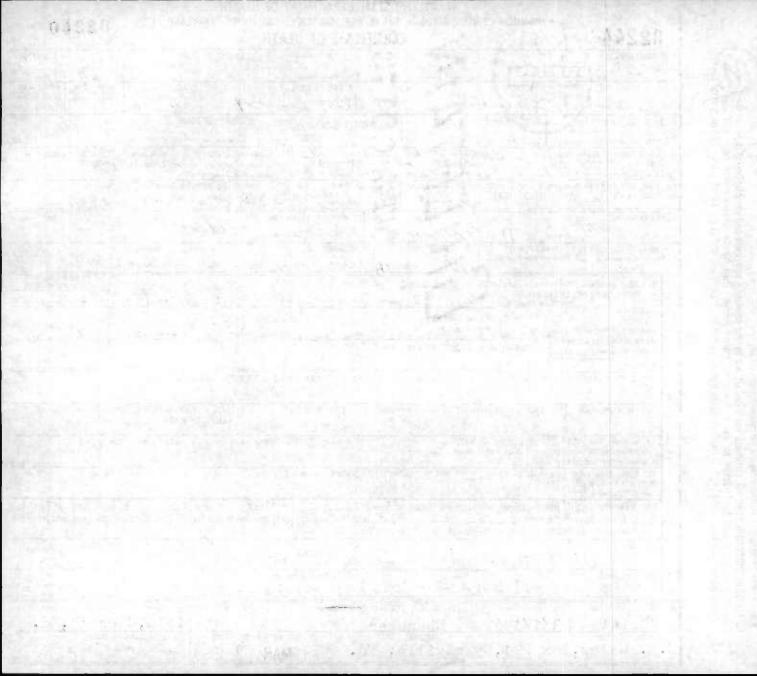
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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| after<br>after<br>after  |     | 3. SE         | Fimile  | 4. RACE  | ht   |                 | DATE OF BIRTH  QC=22-18  | 8#                 | 6. AGE (In years last birthday) YRS. | IF UNDER I FEAR<br>MONTHS CAYS | HOURS MIN.                      |
| hours<br>in by<br>rrs. P   |     | 7a. E<br>cour |   | 3  | WHAT COUNTRY?  |                 | MEVER MARKIED            | 9. COUNTY OF I     |                                      |                                |                                 |
| open 72  | - 1 | 10.0          | TO OR TOWN OF DEATH, or   |  | NAME OF HOSPITAL OR ING  | -               | DIVORCED [               | Carro              | Kind af wark done                    | 12b. KIND OF                   | Md.                             |
| within within  | 90  | 12            | senchester,   | nd.  | NAME OF HOSPITAL OR INS<br>ve street address) / 2<br>- ngveux hu | earny Hor       | nes. during m            | ast of warking li  | fe, even if retired.)                | INDUSTRY                       | DOZINESS OK                     |
|  | 06  |               | USUAL RESIDENCE (Where dissian) STATE   | eceased lived, if insti<br>13b. COUNTY           |  | 13c. Lity OR TO | 1                        |                    | EET AND NUMBER                       | 21979                          |                                 |
| ond co   |     | 14. [         | ATHER'S NAME First  | Middle   | Frence   | e 15. A         | NOTHER'S MAIDEN NAME F   | D. In              | Middle                               |                                | Last                            |
| that the death certificate be executed an.  by the attending physician and comple ransit permit. Then please remove corremation, or removal, and in any even                                 |     | 16a.<br>Y     | WAS DECEASED EVER IN U.S. es, na, ar unknawn) (If yes                                     | . ARMED FORCES?<br>give war or dates of service) | 16b. SOCIAL SECURITY   |                 | DRMANT Losne             | ul w               | Address                              | a. Run                         | (sou)                           |
| th certifiding phy   |     |               | 18. CAUSE OF DEATH (Ent   | AUSED BY:  | line far (a), (b), and (c).                                      |                 | 0                        | 1                  | 14+                                  |                                | NATE INTERVAL<br>NSET AND DEATH |
| attendi<br>permit.   |     |               | 4123  | MEDIATE CAUSE (a)<br>DUE TO. O                   | R AS A CONSEQUENCE OF  | -vor            | mor                      | ace                | colon                                | 24-1                           | vy                              |
| thot the<br>an.<br>by the<br>ransit p  |     |               | Canditians, if any, which g   | qve)   | artery   | relen           | tic He                   | art 1              | meane                                | 3                              | yrs_                            |
| S D T  |     |               | stating the underlying callast.   | USE TO, O  | R AS A CONSEQUENCE OF  |                 |                          |                    |                                      |                                |                                 |
| physi physi signe signe burial   |     |               | PART 2. OTHER SIGNIFICAN  | T CONDITIONS CONTRI                              | BUTING TO DEATH BUT N  | OT RELATED TO T | HE TERMINAL DISEASE OR ( | ONDITION GIVEN     | IN PART I(a)                         |                                |                                 |
| ding<br>een<br>the   |     | NO            | A DITTO CONTRACTOR  | 101 (0110171011501                               | MINISTRACTION WAS DE   | 25021152        | Las Auxonova             | Look is            | WEST THEN THE THE                    | CONCIDENTE IN CE               | DEIEVING                        |
| The la otten otten has b se os the prior   | X   | CERTIFICATION | 19a. DATE OF OPERATION  |  | WHICH OPERATION WAS PE   |                 | 20a. AUTOPSY?  YES NO    | CAUSES             | YES, WERE FINDINGS<br>OF DEATH?      |                                | KIIFYING                        |
| CIAN: The ital or of the ital or of the ital or of the ital of the ital of the ital of the ital ital of the ital of the ital ital of the ital of the ital ital ital ital ital ital ital ital |     | MEDICAL CE    | 21a. ACCIDENT WAS UNDER ON CONTRIBUTING CAUSE COME (If either, natify medical experience) | F DEATH HOUR A.                                  |  |                 | INJURY OCCURRED (Enter   | r nature af injury | in Part 1 ar Part 2,                 | Item 18.)                      |                                 |
| PHYSIC<br>ne hospi<br>this cert<br>etached<br>Dept. o  |     | MEI           | 21d. INJURY OCCURRED While Nat while at wark  | 21e. PLACE OF INJUR                              |  |                 | TION Street ar R.F.D. Na | . City o           | ar Tawn                              | Caunty                         | State                           |
| NG the ter to de   |     |               | 22a   certify that (1)  | (this haspital) a                                | ttended the decease  | ed fram         | 29 , 196                 | 9 , ta 2,          | /2/                                  | OGE, that                      | (H)/(we) last                   |
| ined to OR: Af ould be ould be S   |     |               | saw the decease   | a alive an 2                                     | d) (did nat) view the  | 969 and t       | haf in (my) (aur) api    | nian death á       | ccurred an the d                     | ate and haur o                 | and from the                    |
| be reta  DIRECT  ge 3 sh  led with   |     |               | 22b. SIGNATURE  | 1170   | and u  | DEGREE          |                          | TED.               | STAFF PHYS.  22c.                    | DATE SIGNED                    | 69                              |
| RAL PO   | 1   |               | 22d. PHYSICIAN'S<br>NAME (Type)   | N. HF  | OAN  | uD              | 22e. ADDRESS             | chest              | er u                                 | 1/ 2/1                         | 02                              |
| Page 4 Director Should   |     | 23a.          |   | 23b. DATE  |  | CEMETERY OR CO  |                          | 23d. LOCATION      | V (City ar Tawn)                     | (Caunty)                       | (State)                         |
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| VR A15<br>30M REV.   |     | C.            | FUNERAL DIRECTOR M. Waltz, F  | Box 241,   | ADDRESS<br>Sykesvill   | e, Md.          | 2Sa. REC'D B             | 3 1969             | 2Sb. REGISTRAR'                      | S SIGNATURE                    |                                 |



MARYLAND STATE DEPARTMENT OF HEALTH

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| STANIE | JULIS VERY  | 7.44 C.FFZ." | NONE          |         | 01A - 1 |
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02243 CERTIFICATE OF DEATH 1. DECEASED-NAME Lost 2a. DATE OF DEATH First Middle 2b. HOUR (Type or print) 2-11-1969 Month STANLEY AMBROSE HAHN 3. SEX 4 RACE S DATE OF BIRTH 6. AGE (In years IF UNDER 1 YEAR HOURS Male White 11-22-1894 and completely filled in by 7o. BIRTHPLACE (Stote or foreign 7b. CITIZEN OF WHAT COUNTRY? 9. COUNTY OF DEATH 8. MARRIED NEVER MARRIED Maryland USA DIVORCED [ Carroll WIDOWED X 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12a. USUAL OCCUPATION (Kind of work done 12b. KIND OF BUSINESS OR Sykesville | give street oddress) | Springfield State Hosp. |
| 13a. USUAL RESIDENCE (Where deceased livy(d, if institution: Residence before | 13c. CITY OR TOWN | during most of working life, even if retired.)
Electrician
.mside city umits? 13e. STREET AND NUMBER INDUSTRY carbon executed 13d INSIDE CITY LIMITS? 186. COUNTY admissian) STATE YES NO TO Route 2 remove Washington Smithburg signed by the attending physician and see burial-transit permit. Then please remo burial, crematian, ar remaval, and in any 14. FATHER'S NAME Lost 15. MOTHER'S MAIDEN NAME First ATTENDING PHYSICIAN: The law requires that the death certificate be William Hahn Hattie Wetzel 160. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT (If yes give war or dates of service) Yes, no, ar unknown) Records, Springfield State Hospital 217-10-9527 APPROXIMATE INTERVAL 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) BETWEEN ONSET AND DEAT PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Canditions, if ony, which gave ) Deteco Solecoles rise ta immediate cause (a), DUE TO, OR AS A CONSEQUENCE OF stating the underlying couse, PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO, THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) recenselleni be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been stached far use as the Dept. af Health priar ta CERTIFICATION 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING 20a. AUTOPSY? CAUSES OF DEATH? YES 🗌 NO St 210. ACCIDENT WAS UNDERLYING 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) 21b. TIME OF INJURY OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Month Day Year 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. No. City or Town County Stote While Nat while at work 22a. I **certify** that (I) (this hospital) attended the deceosed from 6-21-66, 19, ta 2-11 saw the deceased alive on 2-11-69, ond that in (my) tow copinion death occurred o \_\_\_\_, 1969 \_\_\_\_, that (I) (we) last , and that in (my) For opinion death occurred on the date and hour and from the causes stated obove, (1) (we) (did) (with rot) view the body after deoth. 22b. SIGNATURE 22c. DATE SIGNED ATTENDING MED. DIRECTOR 2-11-69 DEGREE directar, page shauld be filed PHYS 22e. ADDRESS NAME (Type Glocrite G. Sagisi. M.D. Springfield St. Hosp., Sykesville, Md. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE (County) 23a. BURIAL, CREMATION, Lantz #1. Frederick Co., Md. 2/13/1969 Bethel Cemetery 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR VR A15 (A) Waynesboro, Penna.

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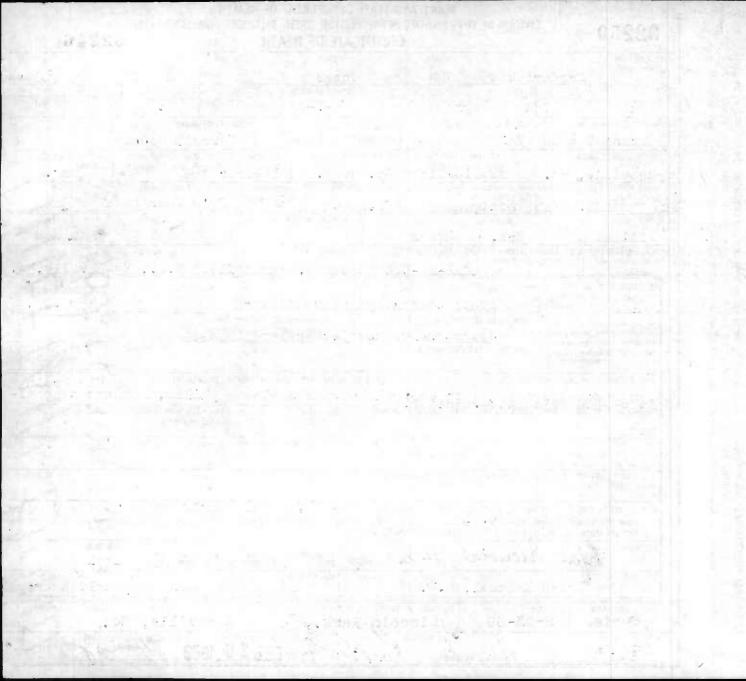
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02248 CERTIFICATE OF DEATH DECEASED-NAME Middle 2a. DATE OF DEATH 2b. HOUR (Type ar print) Feb udresy RRYMAN LE UNDER 1 YEAR IF UNOER 24 HRS. 4. RACE 5. DATE OF BIRTH 6. AGE (In years 3. SEX law requires that the death certificate be executed within 24 haurs after last birthday) remave carban papers. Pages n any event, within 72 haurs aff +6MALE February 9, 1913 9. COUNTY OF DEATH 7o. BIRTHPLACE (State ar fareign 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED NEVER MARRIED country) Maryland U. S. A. DIVORCED Carroll County WIDOWED [ 12o. USUAL OCCUPATION (Kind of work done 11. NAME OF HOSPITAL OR INSTITUTION (If not in haspital 12b. KIND OF BUSINESS OR 10 CITY OR TOWN OF DEATH during most of working life, even if retired.)
Clerical give street oddress) Hospital Carroll Co. Hosp. Westmisster 13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before 13e. STREET AND NUMBER Westmirster 13c. CITY OR TOWN odmissian) STATE Marvland 13b. COUNTY RP 2 Westminster NO TY Box 354 Carroll and in any 14. FATHER'S NAME Lost IS. MOTHER'S MAIDEN NAME First Middle Middle Feig Jo shua Harryman Marv please 16b. SOCIAL SECURITY NO. 17. INFORMANT 21 208 Address 160. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Mr. Clifton W. Harryman 4219 Milford Mill Rd or removal, APPROXIMATE INTERVAL CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
 PART I. DEATH WAS CAUSED BY: BETWEEN ONSET AND OFATH IMMEDIATE CAUSE (a) Conditions, if ony which gove signed by the burial-transit p A50 rise to immediate cause (a), DUE TO, OR AS A CONSEQUENCE OF stoting the underlying couse PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) prior ta TO FUNERAL DIRECTOR: After this certificate has been as the 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING 19g. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? CALISES OF DEATH? YES F far use af Health 21a. ACCIDENT WAS UNDERLYING 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) 21b. TIME OF INJURY OR CONTRIBUTING CAUSE OF OEATH HOUR A.M. Month Day Yeor (If either, notify medical exominer) P.M. detached 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. No. 21d. INJURY OCCURRED City or Town County State While Not while ot work 22a. I certify that (I) (this haspitol) attended the deceased from July saw the deceased alive an Feb 9 19 9, and that his \_19 69, and that my (our) apinian death accurred on the dote and hour and from the be retained couses stated above, (1) (we) (did) (did nat) view the bady ofter deoth. 22c. DATE SIGNED 22b. SIGNATURE ATTENDING PHYS. MED. DIRECTOR TO HOSPITAL OR Page 4 may be r DEGREE 22e. ADDRESS 22d. PHYSICIAN'S NAME (Type) 23d. LOCATION (City or Town)
Pikesville, Md. 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 23b. DATE 23o. BURIAL, CREMATION, 2/18/69 Druid Tidge Cemetery REMOVAL (Specify)
Burisl Balto Co. 24. FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE 21225 Patapsco Ave.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02250 02246 CERTIFICATE OF DEATH DECEASED-NAME Lost 2o. DATE OF DEATH 2b. HOUR death. by the funeral Pages 1 and 2 executed within 24 haurs after death (Type or print) 810aN Frederick NMN Jones IF UNDER 1 YEAR IF UNDER 24 HRS. S. DATE OF BIRTH 4 RACE 6. AGE (In years 3. SEX last birthday) 8-7-12 Male Negro and campletely filled in by the remave carban papers. Pagin any event, within 72 hours 7b. CITIZEN OF WHAT COUNTRY? 9. COUNTY OF DEATH 7o. BIRTHPLACE (Stote or foreign 8. MARRIED NEVER MARRIED country)Pennsylvania USA WIDOWED [ DIVORCED [ Carroll County 12o. USUAL OCCUPATION (Kind of work done 10 CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired.) give street oddress) Springfield unk. St. Hosp. Sykesville, Md. 13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before 13e. STREET AND NUMBER 13c. CITY OR TOWN 13d, INSIDE CITY LIMITS? odmission) STATE COUNTY YES 🕎 NO [ 7010 Thor Lane Bethesda Contromery signed by the attending physician and co burial-transit permit. Then please rema burial, crematian, ar remaval, and in any 15. MOTHER'S MAIDEN NAME First Middle 14. FATHER'S NAME Middle 2 Hughes OR ATTENDING PHYSICIAN: The law requires that the death certificate be William Evans unk. the attending physician sit permit. Then please 16b. SOCIAL SECURITY NO. 17. INFORMANT Address 160. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 '(If yes give war ar dates of service) Yes, no, or unknown) 212-14-5827 Records. Springfield S.H., Sykesville, Md. 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE (AUSE (6) Acute congestive heart failure few min. DUE TO, OR AS A CONSEQUENCE OF Conditions, if ony, which gove (b) Hypertensive cardiovascular disease rise to immediate couse (o), DUE TO, OR AS A CONSEQUENCE OF stoting the underlying couse Page 4 may be retained by the haspital or attending physician. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE ORCONDITION GIVEN IN PART 1(0) Chronic brain syndrome, associated with central nervous system syphilis, memingoencephaldirectar, page 3 shauld be detached far use as the shauld be filed with the State Dept. af Health priar ta O FUNERAL DIRECTOR: After this certificate has been 196. DATE OF OPERATION FIGH CONDITION FOR WHICH OPERATION WAS PERFORMED 20o. AUTOPSY? 20b. IF YES. WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO S YES 🔲 none 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) 21o. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Month Doy Yeor (If either, notify medical examiner) 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. No. 21d. INJURY OCCURRED Stote City or Town County While Not while ot work 22a. I certify that (I) (this hospital) attended the deceased from May 15., 1965, to February 1, 1969, that (I) (we) lost saw the deceased alive on Feb. 17. 1969, and that in (my) (aur) apinian death occurred on the date and haur and from the couses stated abave, (1) (we) (did) (did nat) view the bady after death. 22c. DATE SIGNED 22b. SIGNATURE MED. DIRECTOR STAFF PHYS. ATTENDING 2-17-69 DEGREE 22e. ADDRESS 22d. PHYSICIAN'S pringfield State Hospital, Sykesvi Irfan Esendal, M.D. NAME (Type) 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23b, DATE (County) 23o. BURIAL, CREMATION, REMODAL (Spelify) 2-23-69 Lincoln, Park., Rockville, 25b. REGISTRAR'S SIGNATUR 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 DATEFEB

MARYLAND STATE DEPARTMENT OF HEALTH



| 1 1  | MARYLAND STATE DEPARTMENT OF HEALTH I tem 2a Film G410 3/10 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   | 0/69 kk   |
|--|---|---|
| FOR STATE  |   | 2247  |
| HEALTH DEPT.   | 1. DECEASED-NAME First Middle Last 20. DATE KNOWNED Manth Da  |   |
| is 5 8   | (Type or Print) TOHN MICHAEL KEMP DEATH MATED 2   | 25 189 M  |
| delay<br>and 3<br>43. Po   | 3. SEX 4. RACE S. DATE OF BIRTH 6. AGE (In years lost birthday) 6. AGE (In years lost birthday) MONTHS OAYS HOURS MIN. Month Day.   | Year 2d. HOUR                                   |
| 2, and PM3.  | Male White 6-3-49 19 YRS. February, 25.   | 1969 8:50                                       |
| (1)  | 76. BIRTHPLACE (Stote or foreign   7b. CITIZEN OF WHAT COUNTRY?   8. MARRIED   NEVER MARRIED   9. COUNTY OF DEATH   STORY   NEVER MARRIED   9. COUNTY OF DEATH   WIDOWED   DIVORCED   Carrol   1  | 44.   |
| oages<br>ages<br>ith for   | 10 CITY OR TOWN OF DEATH  11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12a USIAL Of CIPATION (Kind of work done 12b)  | . KIND OF BUSINESS OR                           |
| hours after death<br>Item 18. Give Pages 1,<br>Office along with form<br>1 and 2 with the State De<br>offer death.   | Sykesville Springfield State Hospital Student   | USTRY   |
| s after 18. Give along with it death.  | 13a. USUAL RESIDENCE (Where deceosed liyed, if institution: Residence befare 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET AND NUMBER  |   |
| 24 hours of in Item 18. r's Office ald set I and 2 wi  | Maryland Washington hagerstown 2550 Appletree   |   |
|  | 14. FATHER'S NAME First Middle Last 1S. MOTHER'S MAIDEN NAME First Middle   | Lost  |
| hin 24<br>ncil in<br>niner's<br>pages<br>hours   | John H. Kemp Dorothy  160. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17, INFORMANT ADDRESS   | Swancott  |
|  | (Yes, na, ar unknawn) (If yes give war or dates of service) 166576/Records, Springfield State Hospita   | 1   |
| ed with the in person of the Exor.  1. File in 72  | 1B. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND GEATH |
| be executed pending" in ite Medical E mestigal E event within  | PART I. DEATH WAS CAUSED BY: IMMEDIATE (AUSE (a) Confluent bronchopneumonia, left lung and  | Days  |
| Ent The ex   | 485 X DUE TO, OR AS A CONSEQUENCE OF posterior part of right lung (conditions, if any, which gave )   |   |
| d be<br>chief<br>transit   | rise ta immediate cause (a).  |   |
| shauld be executed to word "pending" in o the Chief Medical E buriol-transit permit. Fin ony event within  | stating the underlying cause last. (c)  |   |
| g the ed to and and  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(0) CBS assoc. with convulsive disorder, with behavioral reaction  |   |
| nis certific<br>nte, writin<br>forward<br>oe used a<br>removal,  | 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 21o. EXTERNAL CAUSE WAS 21b. TIME OF INJURY Month, Doy, Yeor 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item  | 20. AUTOPSY?                                    |
| be be  | WAS PERFORMED?  | YES NO  |
|  | 21o. EXTERNAL CAUSE WAS 21b. TIME OF INJURY Month, Doy, Year PRIMARY OR CONTRIBUTING HOUR A.M. P.M. 19 21d. INJURY OCCURRED 21e. PLACE OF INJURY (At home, form, street). 21f. LOCATION Street or R.F.D. No. City or Town C   | (B.)  |
|  | to a state of the | aunty State                                     |
| 7 7 0  | AT WORK AT WORK   |   |
| ICAL E exect for. Po ed for CTOR: buriol,  | 22a. I certify that I taak charge of the remains described above, held an Autapsy Inspection , Inquiry ,  | and in my apinian                               |
| JICA<br>please ex<br>director.<br>etained<br>DIRECTOR  | death resulted fram: Natural causes 🔀, Accident 🗌, Suicide 🗍, Hamicide 🔲, Undetermined manner 🗌   |   |
| TY Diese<br>erol direct<br>se retaine<br>RAL DIREC   | ACTUAL CHIEF MEDICAL EXAMINER ( 22b. DATE SIGNATURE ) 22b. DATE SIGNATURE ( 22b. DATE SIGNATURE)  | NED CC  |
| ory,   | EXAMINED'S  DEPUTY MEDICAL EXAMINER   DEPUTY MEDICAL EXAMINER   | 25-69   |
| necessory, professory, profess | MAME (Type) W. Glenn Spetcher, M.D. hose screen who thereast  | es Carroll                                      |
| To To He   | 23d. REMOVAL (Specify)  REMOVAL (Specify)  23b. Date  23c. NAME OF CEMETERY OR CREMATORY  23d. LOCATION (City or Town) (Co  REMOVAL (Specify)  24 2 4 6 9 ROSE NILL  14 RERSTEIN  | unity) Proof                                    |
| <u> </u>   | 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGN  |   |
| VR A15ME (5)<br>10M REV. 1/68  | 20.7- Rossnert GTd5 Hog DATE MAR 4 1968 Ichard  | as Judge  |

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|   | 4 de   |                |  |         |         |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH

|                 | CEASED-NAME                                     | First                                  | Middle                |                     | Lost                 | 2a. I           | DATE OF DEATH       |                 |                 | 2b. HOUR                          |
|-----------------|---|--|-----------------------|---------------------|----------------------|-----------------|---------------------|-----------------|-----------------|-----------------------------------|
| (1              | Ype or print) GE                                | ORGE J                                 | MAC                   | KRE                 | IT                   | F               | EB Manth            | 5 Day           | 1969            | 12 A                              |
| 3. SI           |   | 4. RACE                                |                       | S.                  | DATE OF BIRTH        |                 | 6. AGE (II          |                 | IF UNDER 1 YEAR | IF UNDER 24 HRS.                  |
| -               | MALE  | WH                                     | ITE                   |                     | UNE 1                | 8 18            | 87 lastoirt         | YRS.            | AONTHS DAYS     | HOURS MIN.                        |
| ).              | BIRTHPLACE (Stote or foreign                    | 7b. CITIZEN OF WHA                     | T COUNTRY?            | 8. MARRIED TO       | NEVER MARRIED        |                 | NTY OF DEATH        |                 |                 |                                   |
| y               | DO EVI DON                                      | n 11.CA                                |                       | WIDOWED             | DIVORCED             |                 | CAR                 | ROLL            |                 | M                                 |
| ), (            | ITY OR TOWN OF DEATH                            | 11. NAN                                | E OF HOSPITAL OR IN   | STITUTION (If not i |                      |                 | PATION (Kind of v   |                 |                 | BUSINESS OR                       |
| 3               | FD WEST   | MIN STEP give str                      | eet oddress), TE      | サフ                  | durin                | o most of y     | arking life, even   | f retired.)     | INDUSTRY        | Ann                               |
|                 | USUAL RESIDENCE (Where                          | deceosed lived, if institution         | n: Residence befare   | 13c. CITY OR TO     | WN 13d INSIDE        | CITY LIMITS?    | 13e. STREET AND I   | NUMBER          | 14              | 1101                              |
| dm              | 101 010 VI A                                    | NO 13b. COUNTY O                       | PROLL                 | WEST                | 41NS) Fils           | NO Z            | 1                   | -D3             | 7               |                                   |
|                 | ATHER'S NAME First                              | Middle                                 | Last                  | 1S. N               | OTHER'S MAIDEN NA    | ME First        | -                   | Middle          |                 | Last                              |
|                 | JOHN.   | KP                                     | FIT                   |                     | KATH                 | EP1             | NE                  | KI.             | 70              | 4                                 |
| a               | WAS DECEASED EVER IN U.                         |  | AL SOCIAL SECTION     | CH. NE              | RMANI A MC           | ~ I             | IDEIT               | Address         | SON             | )                                 |
| 1               | es, na or unknawn) (If y                        | es give war or dates of service)       | 7 4376                | 7207-17             | O FRIZE              | E               | atten.              | 10              | DOYI            | AND                               |
| =               | 18 CAUSE OF DEATH (Fo                           | ter anly one cause per line            | for (a) (b) and (c)   | )                   | WEST                 | 1111            | 2161                | 7-1-1           | APPROXI         | IMATE INTERVAL<br>ONSET AND DEATH |
|                 | PART I. DEATH WAS                               | CAUSED BY:                             | CALTE                 | CAMB                | FCTIVE               | HE              | ARTE                | AILUK           | FG              | VEAR                              |
|                 | HON IN  | IMEDIATE CAUSE (a)                     | A CONCEOUENCE OF      | 0110                | 23/11/2              | 110             | // 11. / / /        | //              | 0.              | 1610                              |
|                 | Conditions, if ony, which                       | 1 m                                    | A CONSEQUENCE OF      | KEML                | 1-CHR                | ONILC           | RROM                | ICHIT           | 18 9            | YEARS                             |
|                 | rise to immediate couse                         | (o), (b)                               | A CONCLORENCE OF      | DPIT                |                      | 0101            | 1,100,10            |                 |                 | 7 - 11 -                          |
|                 | stoting the underlying c                        | OUSE DUE TO, OK AS                     | A CONSEQUENCE OF      |                     |                      |                 |                     |                 |                 |                                   |
|                 |   | NT CONDITIONS CONTRIBUTI               | NG TO DEATH BUT N     | INT PELATED TO T    | E TEDMINAL DISEASE   | ORCONDITIO      | ON CIVEN IN PART    | 1(a)            | -               |                                   |
|                 | PART 2. OTHER SIGNIFICAL                        | T CONDITIONS CONTRIBUTE                | NO TO DEATH BUT IN    | IOI KELATED TO T    | IL TERMINAL DISEASE  | OKCONDIN        | ON OIVER IN LAKT    | 1(4)            |                 |                                   |
| LEK III LA IION | 19a. DATE OF OPERATION                          | 19b. CONDITION FOR WHIC                | H ODEDATION WAS DE    | PENDMEN             | 20o. AUTOPSY?        |                 | 20b. IF YES. WERE   | FINDINGS COL    | NSIDERED IN C   | FRTIFYING                         |
| 5               | 17d. DAIL OF OFERALION                          | 175. CONDITION TOK WINC                | II OF EXAMON WAS I    | KIOKMED             |                      | 0 🗖             | CAUSES OF DEATH     |                 | IDIDERED III C  | LLCTIT THEO                       |
|                 | 21a. ACCIDENT WAS UND                           | ERLYING 21b. TIME OF                   | MINDY                 | 21c HOW             | INJURY OCCURRED      |                 | of injury in Port   | l or Part 2 Ite | am 181          |                                   |
| MEDICAL         | OR CONTRIBUTING CAUSE                           | OF DEATH HOUR A.M.                     | Month Doy Year        |                     | INDOK! OCCURRED      | (Liller Halare  | s at injury in tori | of Full 2, the  | mi 10.j         |                                   |
| -               | (If either, notify medical 21d, INJURY OCCURRED | examiner) P.M.  21e. PLACE OF INJURY ( |                       | 9 014 LOCA          | TION Street or R.F.D | ) No            | City or Town        |                 | County          | State                             |
|                 | While Mat while                                 | Zie. PLACE OF INJURY                   | OFFICE BUILDING, ETC. | 211. LUCA           | TION Street of K.r.L | J. NO.          |                     |                 | County          | 31016                             |
|                 | at work ot work                                 | 0 /1: 1 : 1) 11                        | 1 1 0 1 14            | 16-21               | MARY                 | 10//            | to Delise           |                 | 19 that         | + (I) (ma) la                     |
|                 | saw the deceas                                  | (this haspital) atter                  | ided the deceas       | ed from 19          | hat in (my) (out)    |                 |                     |                 | e and haur      | ( ) ( 0 )                         |
|                 | causes stated o                                 | ibave, (I) (we) (did) (a               | did nat) view the     | bady after de       | ith.                 | , apinian (     | death accorred      | un me uun       | s unu nuoi      | una muni m                        |
|                 | 22b SIGNATURE                                   | 101160                                 | 1                     | 4470                |                      | 1               |                     | 22c. Di         | ATE SIGNED      | 0.0                               |
|                 | (h) HIM   | W.X11/2UU                              | wer                   | 1/2 LOEGREE         | ATTENDING PHYS.      | MED.<br>DIRECTO | R STAFF PHYS.       | 09              | -5-             | 69                                |
|                 | 22d. PHYSICIAN'S                                | V VV CXX                               | A11 = .               | 14150               | 22e_ADDRESS          |                 | DGE K               | 20170           |                 |                                   |
|                 | NAME (Type)                                     | WIELI                                  | . WEL                 | LIVER               | MV. W                | IEC             | THINS               | TER             | MAR             | MAN                               |
| 3               | BURIAL, CREMATION,                              | 23b. DATE                              | 23c. NAME OF          | CEMETERY OR CR      | EMATORY              | 23d.            | LOCATION (City or   | Town            | (County)        | (Stote)                           |
| 1               | REMOVAL (Specify)                               | 2/8/69                                 | Park                  | ewood               | len .                | 0               | Lette               | m               | a.              |                                   |
| 4.              | FUNERAL DIRECTOR                                | 1                                      | 40 / ADDRESS          | Sain R              |                      | C'D BY REGI     |                     | REGISTRAR'S S   | IGNATURE        |                                   |
| 24              | 1 1   | 11 10                                  | 7 1000                | 200                 | F                    | FR 6            | 1000                | Wilsones        | la . Um         | 100                               |

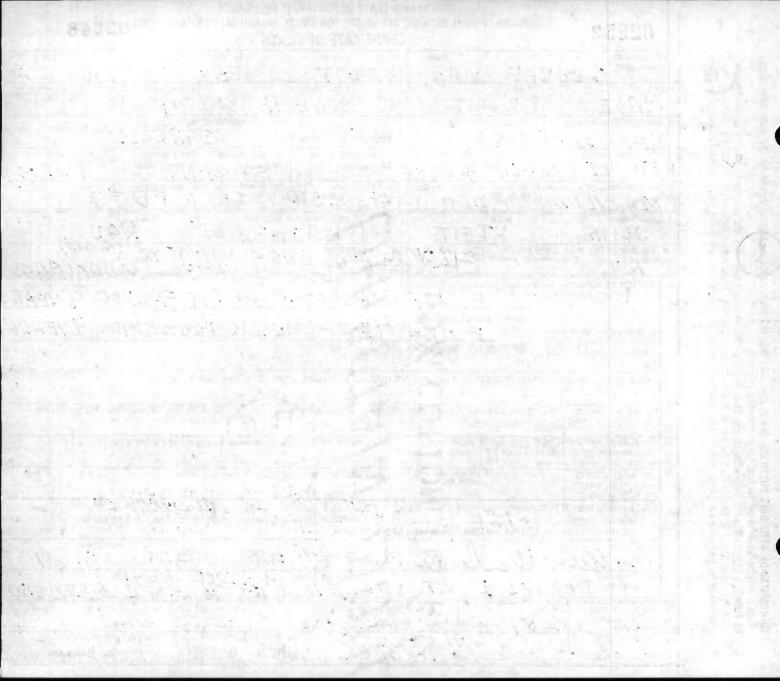
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physical and completely filled in by the director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages should be filed with the State Dept. af Health priar to burial, cremation, ar remaval, and in any event, within 72 hours after the state Dept. VR A15 4

executed within 24 haurs after death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death ceftificate by

Page 4 may be retained by the haspital ar attending physician.

and completely filled in by the fun-remove carban papers. Pages



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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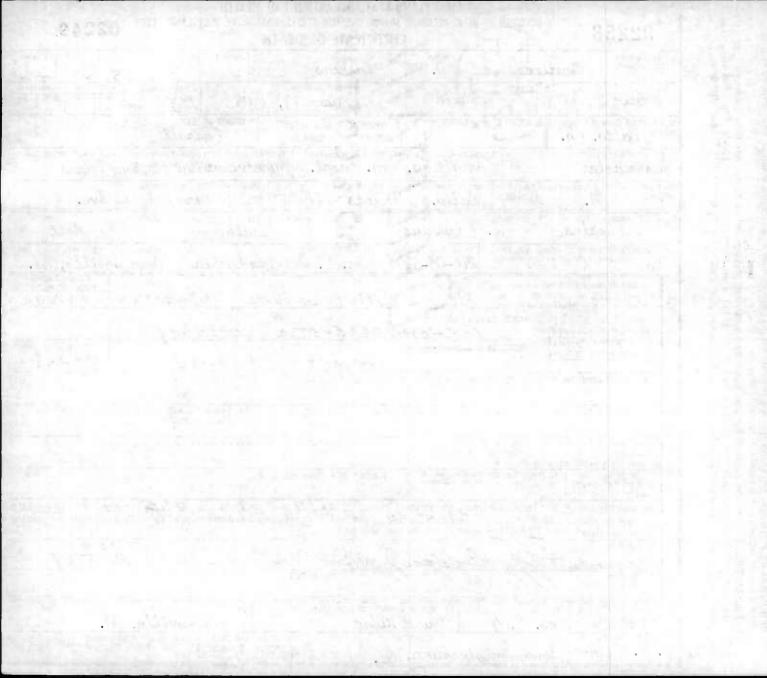
02253 CERTIFICATE OF DEATH DECEASED-NAME First Middle Last 2a. DATE OF DEATH ending physician and campletely filled in by the funefall mit. Then please remave carban papers. Pages 1 and ar remaval, and in any event, within 72 hours after death (Type or print) Maurice Month and campletely filled in by the funeral remave carban papers. Pages 1 and Larkins 3. SEX S. DATE OF BIRTH 4. RACE 6. AGE (In years IF UNDER 1 YEAR White Male March 13, last birthdoy) 1905 7a. BIRTHPLACE (State ar fareign 7b. CITIZEN OF WHAT COUNTRY? 9. COUNTY OF DEATH 8. MARRIED NEVER MARRIED country) Balto. arroll WIDOWED [ DIVORCED [ 10. CITY OR TOWN OF DEATH 12a. USUAL OCCUPATION (Kind af wark dane 11. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital 12b. KIND OF BUSINESS OR Westminster Hospt. diring most of washing life even is retired a NODSIRY 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before 13e. STREET AND NUMBER 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? admission) STATE Md 13b. COUNTY Owings Mil Park Heights Ave. / YES 14. FATHER'S NAME 1S. MOTHER'S MAIDEN NAME First Middle Lost Lost harles Larkins Belt arrie 160. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT Address Yas, no, or unknown) (If yes give war or dates of service) . William Larkins Owings Mills, signed by the attending phy 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (0) INFARCTION HOUTE 1 WEEK crematian, Canditians, if any, which gave ) ROSCLEROTIC rise ta immediate cause (a), stating the underlying causes YEARS +CART PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) as the 190. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20g. AUTOPSY? 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES 🗍 NO 🗌 of far use 21a. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) CAUSE OF DEATH HOUR A.M. Month Doy Year (If either, notify medical examiner) P.M. 21d. INJURY OCCURRED ( AT HOME, FARM, STREET, FACTORY.) 21f. LOCATION Street or R.F.D. No. 21e. PLACE OF INJURY City or Town County Stote While Nat while of work 22a. I certify that (I) (this hospital) attended the deceased from 2/7, 1969, ta 2/16, 1969, that (I) (we) last saw the deceased alive on 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated abave, (I) (we) (did) (did not) view the bady after death. be filed with the 22c. DATE SIGNED DIRECTOR PHYSICIAN'S 22e. ADDRESS NAME (Type) shauld 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Tawn) 23o. BURIAL, CREMATION, 23b. DATE (State) (County) REMOVAL (Spedfy) Feb. 18,69 Pikesville, Md. Druid Ridge FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 2Sb, REGISTRAR'S SIGNATURE line & Sons Reisterstown,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending to FUNERAL DIRECTOR: After this certificate has been director,

te be executed within 24 haurs after death

law requires that the death

attending



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02250

IF UNDER 1 YEAR

2b. HOUR

HOURS

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BETWEEN ONSET AND DEATH

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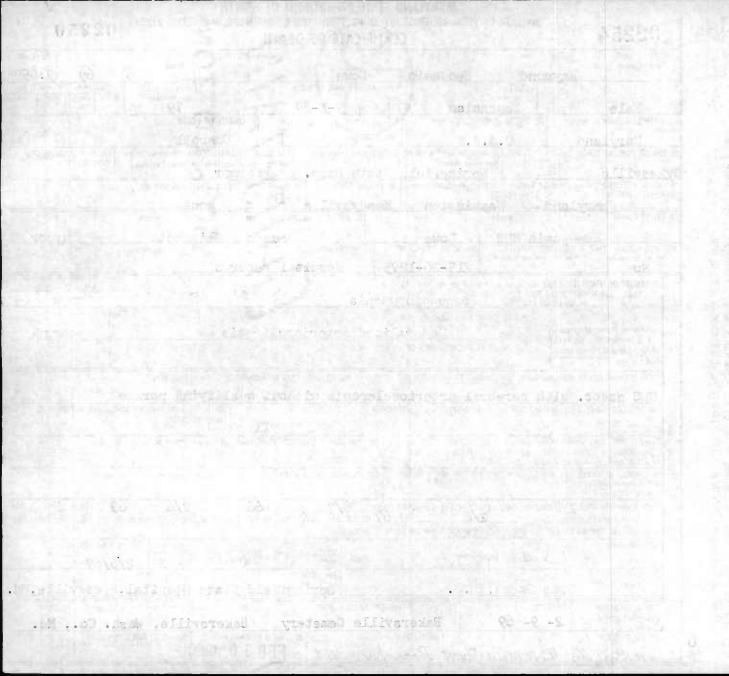
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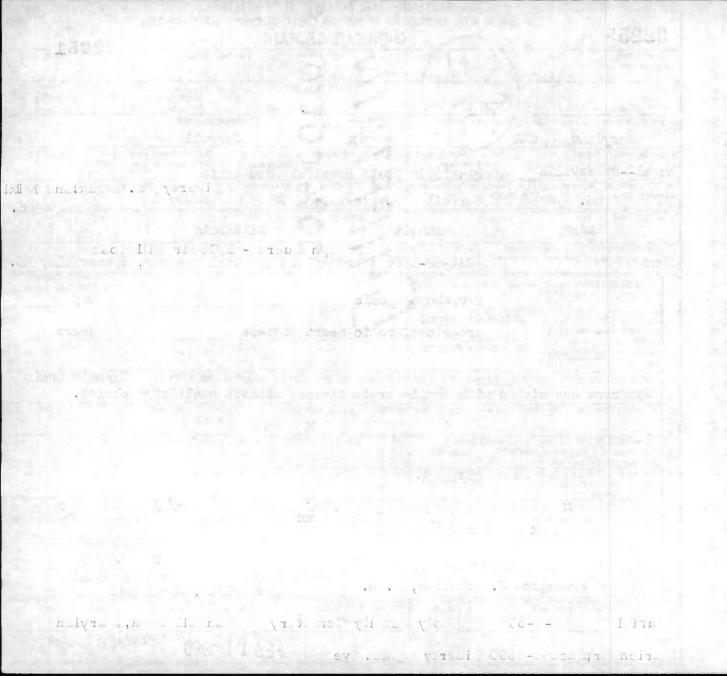
(County)

12b. KIND OF BUSINESS OR

02254 CERTIFICATE OF DEATH DECEASED-NAME First Middle 20. DATE OF DEATH signed by the attending physician and completely filled in by the funeral burial-transit permit. Then please remave tackor papers. Pages I and burial, cremation, ar remaval, and in any event, within 72 haurs after death (Type or print) Month requires that the death certificate be executed within 24 haurs after dea Benjamin Raymond Lowe 3. SEX 4. RACE 5 DATE OF BIRTH 6. AGE (In years lost birthdoy) 9-1-89 Caucasian Male 7a. BIRTHPLACE (State or foreign 7b. CITIZEN OF WHAT COUNTRY? 9 COUNTY OF DEATH 8. MARRIEO NEVER MARRIED country) WIDOWED T DIVORCED | Marvland U.S.A. Carroll 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12o. USUAL OCCUPATION (Kind of work done give street oddress)
Springfield State Hosp. during most of working life, even if retired.) Sykesville 130. USUAL RESIDENCE (Where deceased lived if institution; Residence before 13c. CITY OR TOWN 13e. STREET AND NUMBER 13d. INSIDE CITY LIMITS? Keedvsville None 14. FATHER'S NAME 15. MOTHER'S MAIDEN NAME First Middle Lost Elizabeth Benjamin NMN
160. WAS DECEASED EVER IN U.S. ARMED FORCES? Susan Lowe 16b. SOCIAL SECURITY NO. 17 INFORMANT Yes, no, or unknown) (If yes give war or dates of service) 215-26-1295 Hospital records 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if ony, which gove Generalized arteriosclerosis rise to immediate couse (a). DUE TO, OR AS A CONSEQUENCE OF stoting the underlying couse PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 160 as the priar tak attending O FUNERAL DIRECTOR: After this certificate has been CBS assoc. with cerebral artermosclerosis without qualifying phrase 20b. IF YES, WERE FINOINGS CONSIDERED IN CERTIFYING 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19o. DATE OF OPERATION 20o. AUTOPSY? CAUSES OF DEATH? YES 🗀 be detached far use State Dept. of Health O HOSPITAL OR ATTENDING PHYSICIAN: 1 Page 4 may be retained by the haspital ar 210, ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 21c, HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 1B.) OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Month Doy Year (If either, notify medical examiner) 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,) 21f. LOCATION Street or R.F.D. No. City or Town While Not while at work 220. I **certify** that 1) (this haspital) attended the deceased from 6/7, 1966, to 2/6, 1969, that (1) (we) last saw the deceased alive an 2/6, 1969, and that in (1) (aur) apinion death occurred an the date and hour and from the 2/6 , 1969 , that (X (we) last 3 shauld directar, page 3 shauld shauld be filed with the causes stated above, (1) (we) (did) (did nox) view the bady after death. 22b. SIGNATURE MED. DIRECTOR Sule Ozgeny DEGREE 22d. PHYSICIAN'S 22e. ADDRESS NAME (Type) Suha Ozgun, M.D. Springfield State Hospital, Sykesville, Md. 230. BURIAL, CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b. DATE 2- 9- 69 Bakersville Cemetery Bakersville, Wash. Co., Md. 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR

Ichn H. BAST, Je 112 N. Main Street Boonshope Md DATE EB 10 1969





| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BAITHORE, MARYLAND 21201  0.2252    Control of Part  | 11   | 1      | MARYLAND STATE DEPARTMENT OF HEALTH   |
|--|--|--------|---|
| TO STATE    Comparison   Compar |  |        | 00000   |
| (Type or Print)  A RACE (September 1)  S. DATE OF BIRTH (See September 1)  S. DATE OF BIRTH (See Septe | FOR STATE  |        | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |
| 1. SEX.   RACE   S. DATE OF BIRTH   A REF   In your   Student Text   S. DATE OF BIRTH   A REF   In your   Student Text   S. DATE OF BIRTH   A REF   In your   Student Text   S. DATE OF BIRTH   A REF   In your   Student Text   S. DATE OF BIRTH   A REF   In your   Student Text   S. DATE OF BIRTH   A REF   In your   Student Text   S. DATE OF BIRTH   A REF   In your   Student Text   S. DATE OF BIRTH   A REF   In your   Student Text   S. DATE OF BIRTH   A REF   In your   Student Text   S. DATE OF BIRTH   A REF   In your   Student Text   S. DATE OF BIRTH   S. DATE  | HEALTH DEPT.                                     | 1. [   | Type or Print) OF ESTI-   |
| TO THE PRINCE (Sint or foreign   75. CHIZHO OF WAIT COMINT?   8. MARRID   NOVER MARRED   9. COUNTY OF BEATH   10. WISCOMING    | - CA   | 3 6    |   |
| 10. CETT OR TOWN OF DEATH  11. NAME OF ROSPITAL OR INSTITUTION (If not in hospital days) in the part of the part o | and and orthwest                                 | J.,    | lost birthday) Months DAYS HOURS Min. Month > Day / Year  |
| 10. CUTY OR TOWN OF BEATH  11. NAME OF HOSPITAL OR HESTIDITION (If not an hospital piece with griffing in street objects)  12. USUAL RESIDENCY (Where decessed lived, if institutions residence before 15 U.TT OR TOWN  13. USUAL RESIDENCY (Where decessed lived, if institutions residence before 15 U.TT OR TOWN  13. USUAL RESIDENCY (Where decessed lived, if institutions residence before 15 U.TT OR TOWN  13. USUAL RESIDENCY (Where decessed lived, if institutions residence before 15 U.TT OR TOWN  13. USUAL RESIDENCY (Where decessed lived, if institutions residence before 15 U.TT OR TOWN  14. FATHERS NAME  13. USUAL RESIDENCY (Where decessed lived, if institutions residence before 15 U.TT OR TOWN  15. MOTHERS MANDE NAME  15. MOTHERS NAME  15. MOTHERS NAME  16. CAUSE OF DEATH  16. CAUSE OF DEATH  18. CAUSE OF DEATH  18. CAUSE OF DEATH  18. CAUSE OF DEATH  19. DEATH WAS CAUSED BY:  19. DEATH OF TOWN  19. CONSTITUTION (III not hopping live very legisland)  19. DEATH OF TOWN  15. MOTHERS NAME  15. MOTHERS NAME  15. MOTHERS NAME  16. DEATH WAS CAUSED BY:  17. NOTHERANITY ON A. DAVIS SETTING OF TOWN  18. CAUSE OF DEATH (Enter only one cause per line leg (p), (b), ond (c))  19. DEATH OF TOWN  19. CONSTITUTION (III of the work) control work of the control work o | orm in   |        |   |
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| Companies   Control   Co   | ours<br>em<br>ffice<br>ind 2                     | 14.    |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  190. DATE OF OPERATION  190. DATE OF OPERATION  190. CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  190. DATE OF OPERATION  190. CONDITION FOR WHICH OPERATION  WAS PERFORMED?  YES NO DEPLOY  190. DATE OF OPERATION  190. CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  20. AUTOPSY?  YES NO DEPLOY  YES NO DEP |  |        | JAMES EDWARD DAVIS MARY ELIZABETH SHUEY   |
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| 21d. INJURY OCCURRED WHILE AT WORK AT  | d d  |        | PRIMARY OR CONTRIBUTING HOUR A.M.   |
| 220. I certify that I took chorge of the remoins described obove, held an Autapsy, Inspection, Inquiry, ond in my opinion death resulted from: Natural causes, Accident, Suicide, Hamicide, Undetermined monner, CHIEF MEDICAL EXAMINER, ACTUAL SIGNATURE, ASSISTANT MEDICAL EXAMINER, ASSISTANT MEDICAL EXAMINER, ASSISTANT MEDICAL EXAMINER, ADDRESS(Street, city, town, or county)  230 BURIAL, DREMATION, 23b. DATE, 23c. NAME OF CEMETERY OR CREMATORY, 23d. LOCATION (City or Town), Caunty), County), County), County, Co   | 3 3 3 3 S T T T T T T T T T T T T T T T          | ME     | 21d. INJURY OCCURRED 21e. PLACE OF INJURY (At home, form, street, while Not while Not while not while factory, office building, etc.)  21f. LOCATION Street or R.F.D. No. City or Town County State |
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|               | CEASED-NAME First ype ar print) WAZ   | Middle  TER WILL  4. RACE  |                         | Last MILLER  DATE OF BIRTH        | 2a. DATE OF D                             | Manth Day                          | Year<br>1969<br>IF UNDER 1 YEAR | 2b. HOUR  6 2 M  IF UNDER 24 HRS.        |
| 0. 32.        | MALE  | WH17E  |                         | JULY 10                           |   |                                    | MONTHS DAYS                     | HOURS MIN.                               |
| 70. 8<br>caun |   | b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED WIDOWED      | -7                                |   | PROLL C                            | 20.                             | Md                                       |
|               | ITY OR TOWN OF DEATH<br>FINKSBURG   | 11. NAME OF HOSPITAL Of give street address)   | OR INSTITUTION (If not  |                                   | SUAL OCCUPATION (I<br>mast af warking lif | e, even if retired.)               | 12b. KIND OF E<br>INDUSTRY      | BUSINESS OR                              |
|               | USUAL RESIDENCE (Where deceased sisten) STATE   | lived, if institution: Residence be  | fare 13c. CITY OR 1     |                                   | Y LIMITS? 13e. STRE                       | ET AND NUMBER                      |                                 |  |
| 14. F         | ATHER'S NAME First PETE   | Middle Lo  | 2LER 15.                | MOTHER'S MAIDEN NAME              | First                                     | Middle                             |                                 | Last                                     |
|               | WAS DECEASED EVER IN U.S. ARMEI<br>es, na ar unknawn) (If yes give wor                          | or dates of service) 16b. SOCIAL SECU<br>2/7-36-   |                         | FORMANT<br>FAS, H-MI              | ILLER                                     | Address<br>NESTMIN                 | STERI                           | Md.<br>RT#Y                              |
|               | 18. CAUSE OF DEATH (Enter only<br>PART I. DEATH WAS CAUSED                                      | BY:  |                         | a lors in                         |   |                                    |                                 | MATE INTERVAL NSET AND GEATH LINUX       |
|               | Canditions, if any, which gave)   | DUE TO, OR AS A CONSEQUENC   |                         |                                   |   |                                    |                                 |  |
|               | rise ta immediate cause (a), stating the underlying cause last.                                 | DUE TO, OR AS A CONSEQUENC   | E OF                    | tie hea                           | rt dia                                    | case                               | note                            | icid year                                |
| 2             | PART 2. OTHER SIGNIFICANT COND  | ITIONS CONTRIBUTING TO DEATH B   | UT NOT RELATED TO       | THE TERMINAL DISEASE C            | R CONDITION GIVEN                         | IN PART 1(a)                       |                                 | V  |
| CERTIFICATION | 19a. DATE OF OPERATION 19b. CC  | ONDITION FOR WHICH OPERATION W   | AS PERFORMED            | 20a. AUTOPSY? YES NO              | CALISES                                   | YES, WERE FINDINGS CO<br>OF DEATH? | ONSIDERED IN CE                 | RTIFYING                                 |
| MEDICAL CER   | 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF OEATH (If either, natify medical examine | HOUR A.M. Manth Day  |                         | W INJURY OCCURRED (Er             | nter nature of injury                     | in Part 1 ar Part 2, I             | tem 18.)                        |  |
| ME            | 21d. INJURY OCCURRED 21e. P While Nat while at wark   | LACE OF INJURY (AT HOME, FARM, STRI<br>OFFICE BUILDING, ETC  | EET, FACTORY.) 21f. LOC |                                   |   | r Tawn                             | County                          | State                                    |
|               | 22a. I certify that (I) (this   | hospital) attended the development of the developme | 19 <u>&lt; G8</u> , and | thot in (my) (our)                | opinion death ac                          | curred on the do                   | te and haur o                   | (I) <del>(we) l</del> as<br>and from the |
|               | 22b. SIGNATURE  | Pillingsle   | a MADEGRE               | E PHYS.                           | MED. DIRECTOR                             | STAFF                              | DATE SIGNED                     | 69                                       |
|               | 22d. PHYSICIAN'S<br>NAME (Type)   | Billingoleo  | (, 1771)                | 22e. ADDRESS<br>Wests             | ninete                                    | m, me                              | ·Co                             |  |
| 23a.          | BURIAL, CREMATION, 23b. DA  |  | NE OF CEMETERY OR       | REMATORY                          |   | (City or Town)                     | (Caunty)                        | (State)                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital ar attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and campiately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages and should be filed with the State Dept. at Health prior ta burial, cremation, ar removal, and in any event, within 72 haurs after deal

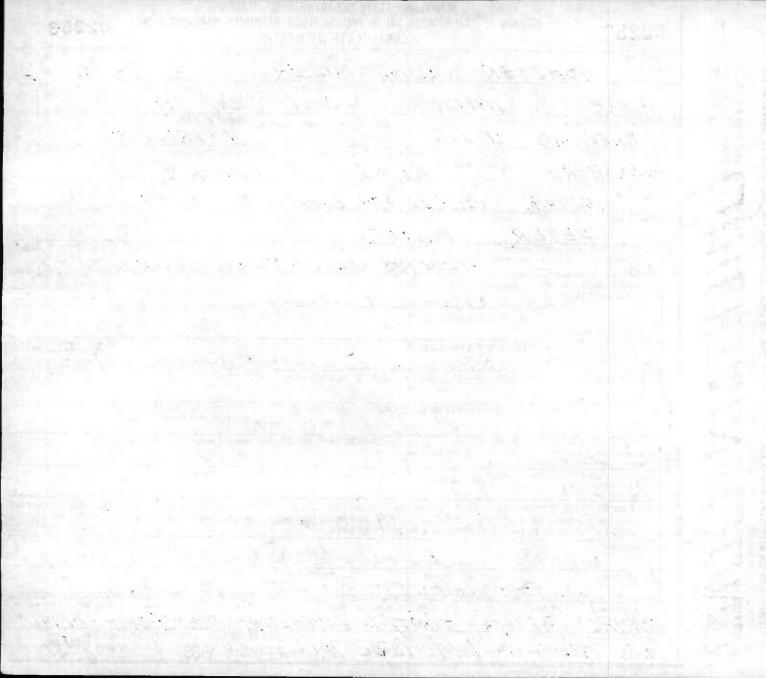
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REC'D 2Sa.

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BY REGISTRAR

25b. REGISTRAR'S SIGNATURE 1969



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# FOR STATE HEALTH DEPT.

necessary, please execute the certificate, writing the ward "pending" in pencifyin Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shalld he forwarded to the funeral director. s Office along with farm PM3. Page 5 may be retained far your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages, land 2 with the State Department on Health priar to burial, crematian, ar remaval, and in any event within 72 haurs after death. the funeral directar. Page 4 shauld be forwarded ta the Chief Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02256

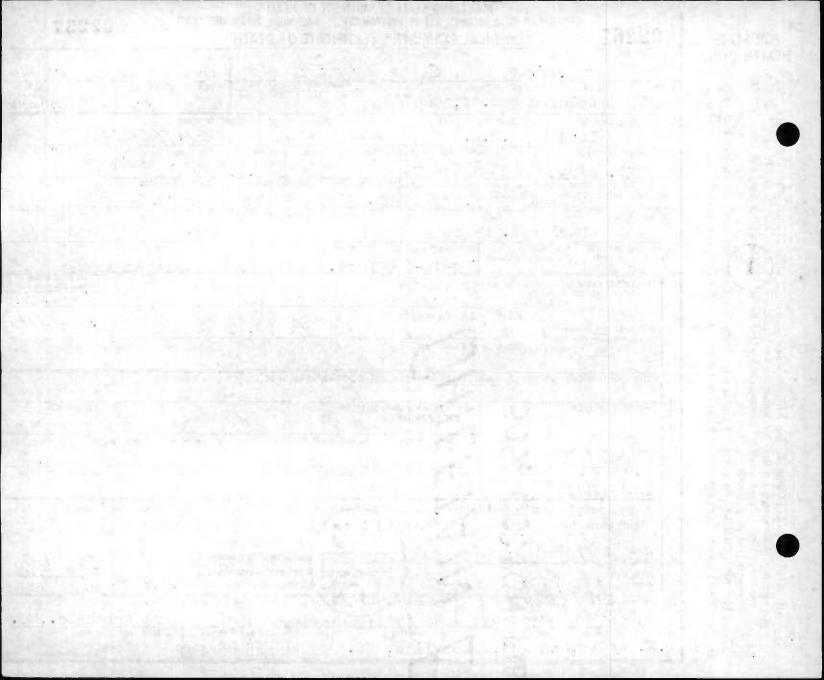
|   |   | MEDICAL                              | LYMINITE   | 2 CEL           | HILLOWIE                            | OI DE   | AIII                           |   |                        |                         |
|---|---|--------------------------------------|--|-----------------|-------------------------------------|---|--------------------------------|---|------------------------|-------------------------|
| 1. DECEASED-NAME<br>(Type or Print)               | First<br>LEWIS                                | Louis                                | Middle<br>ELDON  |                 | MUNCH                               | I   |                                | 20. DATE KNOWN Month DO OF ESTI-DEATH MATED 2/19    | 1969                   | 2b. HOUR                |
| 3. SEX Male                                       |   | S. DATE OF BIRTH<br>Aug. 25,         | 1912 6. AGE  |                 | IF UNDER 1 YEAR AONTHS DAYS         | IF UNDER<br>HOURS                                   | 24 HRS.                        | 2c. DATE PRONOUNCED DEAD February Day,              | Yeor 169               | 2d ноця<br>9:20<br>Р. м |
| 7o. BIRTHPLACE (Sto country) W . T                | ote or foreign 7b. Virginia                   | U.S.A.                               | COUNTRY? 8   | . MARR<br>WIDOW | IED NEVER MA                        | RRIED _   | 9. COU                         | ONTY OF DEATH  CARROLL                              |                        | Mo                      |
| 10. CITY OR TOWN O                                |   |                                      | OF HOSPITAL OR INS<br>t oddress)<br>nchester   |                 |                                     | 120. U<br>during<br>Re                              | SUAL OC<br>most o              | f working life, even if retired.) IN                | b. KIND OF BUSINDUSTRY |                         |
| 13 o. USUAL RESIDER<br>odmission) STAT            | NCE (Where deceosed<br>E Md.                  | lived, if institution 13b. COUNTY CA | Residence before   |                 | minster                             | 3d. INSIDE CITY                                     | LIMITS?                        | 13e. STREET AND NUMBER 184 William Avo              | enue                   |                         |
| 14. FATHER'S NAME<br>Edgai                        | First   | Middle<br>Eldon                      | lost<br>Munch  | 1               | S. MOTHER'S MAI                     | IDEN NAME   | First                          | Middle<br>Lizabeth                                  | lost<br>Dent           |                         |
| 160. WAS DECEASED E<br>(Yes, no, or unkno<br>11 O | VER IN U.S. ARMED FOR<br>wn) (If yes give war |                                      | SOCIAL SECURITY NO   |                 | INFORMANT<br>Mrs. Ch                | arlo  | tte                            | ADDRESS Will<br>S. Munch, Westm                     | iam Ave                | Md                      |
| rise to imme stoting the ulast.  PART 2. OTHER    |   | (b)                                  | A CONSEQUENCE OF  A CONSEQUENCE OF  TO DEATH BUT NOT FOR WELL ASSESSMENT OF THE PROPERTY OF TH | 41.5            |                                     | DIS <b>E</b> ASE OR (                               | CONDITIO                       | disease   | 20. AUTOPSY            | 7                       |
| 190. DATE OF 210. EXTERNAL                        | CALLER MAC                                    | 2517                                 | WAS PERFORMED?   |                 | 85-15                               |   |                                |   | YES X                  | NO 🔲                    |
| PRIMARY X CAUSE OF DEA                            | OR CONTRIBUTING                               |                                      |  |                 | LOCATION Street                     |   |                                | re of injury in Port 1 or Port 2, Item City or Town | County                 | Stote                   |
| 22a. I  | certify that I tag<br>esulted fram:<br>Charl  | Natural causes                       |  | a.              | Suicide ,<br>CHI<br>M.D. ASS<br>DEP | Hamicid<br>EF MEDICAL<br>SISTANT MED<br>PUTY MEDICA | de, EXAMINI PICAL EXA AL EXAMI | MINER 22b. DATE SIG                                 |                        |                         |
| 230. BURIAL, CREMA                                | 增加 2/2  | ATE<br>4/69                          | 23c. NAME OF C   | ew M            |                                     |   | S                              | ykesville, RD.                                      | Md.                    | ote)                    |
| 24. FUNERAL DIRECT                                |   | Jugato                               | ADDRES   | mid             | ,                                   | 2So. REC'I  |                                | 1969 25b REGISTRAR'S SIG                            | NATURE                 |                         |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH

|               | 02263   |                                 |                                | VITAL RECORDS,   |        | CATE OF                | DEATH                 | , , , , , ,        |  |                    | 0225                        | 4,                             |
|---------------|---|---------------------------------|--------------------------------|--|--------|------------------------|-----------------------|--------------------|--|--------------------|-----------------------------|--------------------------------|
|               | ASED-NAME<br>be or print)   | First                           | Rosa                           | Middle<br>Virginia                                     | a ?    | Lost                   | O'Haro                | 2a. DATE OF        |  | 1 Doy              | 69 <sup>yeor</sup>          | 2b. HOUR<br>8:00 N             |
| 3. SEX        | female  |                                 | 4. RACE                        | white  |        | S. DATE OF E           | IRTH<br>L/28/82       |                    | 6. AGE (In ye                          | ears<br>Y)<br>YRS. | IF UNDER 1 YEAR MONTHS OAYS | IF UNDER 24 HRS.<br>HOURS MIN. |
| countr        | maryran   | 9                               | U                              | THAT COUNTRY?  | WIDOWE |                        | RCED X                | Carro              | 11                                     |                    |                             | Mo                             |
| Ru            | Y OR TOWN OF DEATH  |                                 | give<br>Spi                    | IAME OF HOSPITAL OR IN<br>street address)<br>ringfield | State  | Hospit                 |                       | of working         | (Kind of wor<br>life, even if ro<br>Ce | etired.)           | INDUSTRY                    | BUSINESS OR                    |
| odmiss        | ion) STATE Md.  |                                 | 13b. COUNTY                    | tion: Residence before                                 | Midd   | leburg                 | YES 700               | D 1                | neret and num                          |                    |                             |                                |
|               |   | harle                           |                                |  | ro     |                        | AIDEN NAME Fir<br>Fai | nie                |  | iddle              | Eswo                        | rthy                           |
| 16a. V<br>Yes | vas deceased ever in<br>, no er unknown)  | U.S. ARMED<br>If yes give wor o | FORCES?<br>r dates of service) | 16b. SOCIAL SECURITY 218-54-340                        |        | . INFORMANT<br>oringfi | eld Hos               | pital 1            | 110                                    | dress<br>S S       |                             | le, Md.                        |
| 1             | B. CAUSE OF DEATH PART I. DEATH WA  | C CALICED D                     | V                              | ine far (a), (b), and (c)  Congesti                    |        | art fai                | lure                  |                    |  |                    |                             | ONSET AND GEATH                |
| r             | anditions, if any, whi<br>ise to immediate cau<br>tating the underlying<br>ast.   | ise (a), (                      | (b)                            | AS A CONSEQUENCE OF                                    |        |                        |                       |                    |  |                    |                             |                                |
|               | syndrome a  | ssoci                           | ated w                         | uting to DEATH BUT N<br>ith senile                     | brain  | n disea                | se with               | behav:             | ioral r                                | eac                | tion.                       |                                |
| STIFICA       | 9a. DATE OF OPERATION   |                                 |                                | HICH OPERATION WAS PE                                  |        | 20o. AUT               | NO 🔀                  | CAUSES             | OF DEATH?                              |                    | ONSIDERED IN C              | EKIIFTING                      |
| 3             | Ta. ACCIDENT WAS UI<br>☐ OR CONTRIBUTING ☐ CA<br>If either, natify medic  | SE OF OEATH                     | ) P.M.                         | Manth Day Yeor   | 9      | HOW INJURY O           | CURRED (Enter         | noture of inju     | ry in Part 1 ar                        | Part 2,            | Item 1B.)                   |                                |
| 0             | 21d. INJURY OCCURRED<br>While Nat while t<br>twork at wark  | J .                             |                                | ( AT HOME, FARM, STREET, FA<br>OFFICE BUILDING, ETC.   |        | LOCATION Stre          |                       |                    | ar Tawn                                |                    | Caunty                      | State                          |
|               | 22a. I certify that (x) (this haspital) attended the deceosed from 8/21/, 1967, ta 2/1/, 1969, saw the deceased alive on 2/1/, 1969, and that in (1995) (aur) apinian death accurred on the date and has causes stated above, (x) (we) (did) (diabout) view the body after death. |                                 |                                |  |        |                        |                       |                    |  | and fram th        |                             |                                |
| 1             | ATTENDING - MED - STACE -   |                                 |                                |  |        |                        |                       | DATE SIGNED 2/4/69 | 1                                      |                    |                             |                                |
|               | NAME (Type)   |                                 |                                | ukunsal, M   |        |                        | Syl                   | kesvil             | le, Mai                                | cyla               | nd                          |                                |
| Bu            | BURIAL, CREMATION,<br>REMOVAL (Specify)   | 23b. DA                         | 1969                           | Mount  | Olive  | t Cemet                | ery                   | Frede              | on (City or Tov                        | Fre                | (County)                    | (Stote) Md.                    |
|               | INERAL DIRECTOR   | ailey,                          | Son Son                        | Freder   | rick.  | Marylan                | DATE D                | REGISTRAR          | 73625                                  | SISTRAR'S          | SIGNATURE                   | 94                             |

Proge 4 may be retained by the nospiral or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove-carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02260

02264 CERTIFICATE OF DEATH DECEASED-NAME Starffey Middle Penman 20. DATE OF DEATH THE HOUSE PI low requires that the death certificate be executed within 24 hours after death (Type ar print) Dov Remains and the second an and completely filled in by the fune ise remove corbon popers. Pages 1 of indispary event, within 72 hours after de IF UNDER 1 YEAR 3. SEX 5. DATE OF BIRTH 6. AGE (In years last birthday) HOURS Male 7-16-90 White 7o. BIRTHPLACE (State or foreign 7b. CITIZEN OF WHAT COUNTRY? 9. COUNTY OF DEATH 8. MARRIED NEVER MARRIED X country) Maryland Allegany U.S.A. WIDOWED [ DIVORCED Carroll 11. NAME OF HOSPITAL OR INSTITUTION (If not in haspital 10. CITY OR TOWN OF DEATH 12o. USUAL OCCUPATION (Kind of work done 12b. KIND OF BUSINESS OR give street address)
Springfied State Hosp during most of working life, even if retired.)
R. R. Brakeman **INDUSTRY** Sykesville Railroad 13a, USUAL RESIDENCE (Where deceased lived, if institution; Residence before 13c, CITY OR TOWN 13e STREET AND NUMBER 13d. INSIDE CITY LIMITS? admission) STATE COUNTY YES T NO. Allegany Barton סחס היסהס 14. FATHER'S NAME 1S. MOTHER'S MAIDEN NAME First First Middle Lost Middle Last John Penman Mackey None 160. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT Yes, no, or unknown) I (If yes give war ar dates of service) or removal, Records None Hospital APPROXIMATE INTERVAL 18. CAUSE OF DEATH (Enter only one couse per him for (o), (b), ond (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) BETWEEN ONSET AND DEATH cremation, DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gove burial-tronsit rise to immediate couse (a), DUE TO, OR-AS A CONSEQUENCE OF be retained by the hospital or attending physician. stoting the underlying couse signed t burial, PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) TO HOSPITAL OR ATTENDING PHYSICIAN: The low re Poge 4 may be retained by the hospital or attending to FUNERAL DIRECTOR: After this certificate has been for use os the 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING 19o. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? CAUSES OF DEATH? NO S YES [ of Health 21o. ACCIDENT WAS UNDERLYING 21b. TIME OF INJURY 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Manth Doy (If either, natify medical examiner) P.M. be detoched (AT HOME, FARM, STREET, FACTORY,) 21f. LOCATION Street or R.F.D. No. with the State Dept. 21d. INJURY OCCURRED 21e. PLACE OF INJURY City or Town County State While Not while at work 22a. I certify that (1) (this hospital) attended the deceased fram\_\_\_\_ the deceased fram 12-1-, 19-32, ta 2-18-19-69, that (I) (we) last 2-18-19-9, and that in (my) (our) opinion death accurred on the dote and hour and from the 2\_78\_19\_60 , that (1) (we) last saw the deceased alive an\_\_\_\_ ploods couses stoted above, (I) (we) (did) (did not) view the body after deoth 22b. SIGNATURI 22c. DATE SIGNED **ATTENDING** MED. DIRECTOR , page 3 PHYS 22e. ADDRESS 22d. PHYSICIAN'S Springfield State Hospital NAME (Type) Gracito Patricio director, should b 23a BURIAL CREMATION 23b, DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) on. My unce esternoon FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (4) DATE FEB 2 4 ERN DOR

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remaye carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

VR A15 45M - 1,

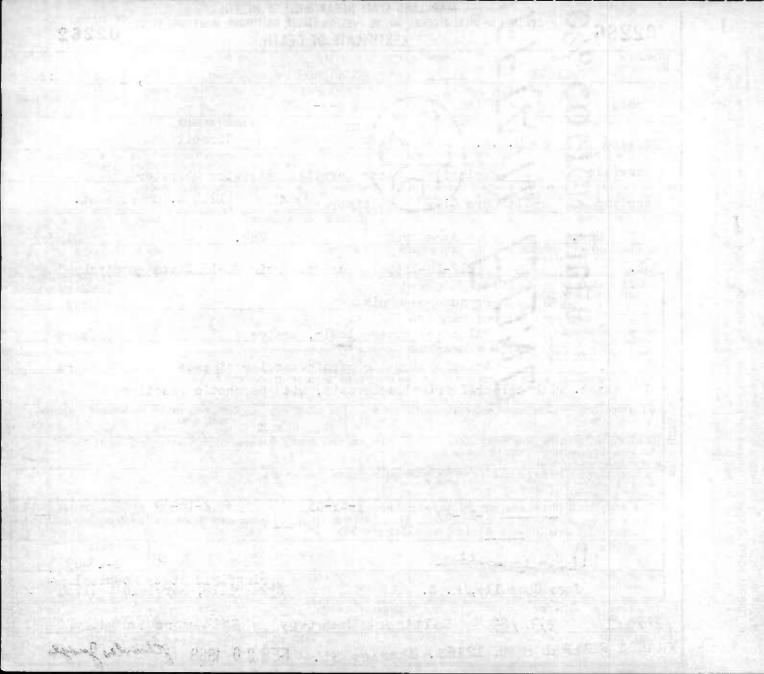
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02262

|               | CEASED-NAME<br>ype or print)   | First  | Middle   |                                | Lost   | 20.              | DATE OF DEATH   |                          | 2b. HOUR                         |
|---------------|--|--|--|--------------------------------|--|------------------|---|--------------------------|----------------------------------|
| 11            | ype of print) WI   | LBUR   | ALLEN  | RO                             | CKSTROH  |                  | FEBRUARY 18.  | 1969                     | 7:20P                            |
| 3. SE.        | x<br>Male  | 4. RACE Wh   | ite  |                                | 5. DATE OF BIRTH<br>8-9-1890                         |                  | 6. AGE (In years lost birthdoy) 78 YRS.   | MONTHS DAYS              | IF UNDER 24 HRS.<br>HOURS MIN    |
| coun          | laryland   | U.S.A  | ,  | WIDOWED [                      |  |                  | UNTY OF DEATH Carroll   |                          | Mc                               |
| S             | ITY OR TOWN OF DEATH Sykesville USUAL RESIDENCE (Where de                                    | give s   | AME OF HOSPITAL OR INSTI-<br>treet oddress)<br>ringfield S             | tate 3c. CITY OR               | Hospita during                                       | most of<br>Cleva | CUPATION (Kind of work dane working life, even if refired.)  tor Operator  13e. STREET AND NUMBER | 12b. KIND OF<br>INDUSTRY | BUSINESS OR                      |
| admi          | Maryland   | Zaltimo  | re City  | Balti                          | more YESK  | NO 🗌             | 1214 S. Char  | les St.                  |                                  |
| 14. F         | ATHER'S NAME First   | Middle   | Lost   |                                | MOTHER'S MAIDEN NAM                                  |                  | Middle  |                          | Lost                             |
| 16a.          | WAS DECEASED EVER IN U.S.  | . ARMED FORCES?  | Rockstro 16b. SOCIAL SECURITY NO                                       |                                | FORMANT  | Unk.             | Address   | B.                       | lades                            |
| Y             | es no, or unknown) (If yes   | give war or dates of service)  | 217-14-165   | 9 R                            | ecords. Spr  | ingf             | ield State Ho   | spital                   |                                  |
|               | 18. CAUSE OF DEATH (Ente   | ALICED DV  |  |                                |  |                  |   | APPROXI<br>BETWEEN O     | MATE INTERVAL<br>INSET AND DEATH |
|               | PART I. DEATH WAS CO   | MEDIATE CAUSE (o) B  | ronchopneum  | onia                           |  |                  |   | Days                     | 3                                |
|               | Canditions, if ony, which g<br>rise to immediate couse<br>stoting the underlying co<br>last. | (o), DUE TO, OR A  | S A CONSEQUENCE OF<br>ulmonary tu<br>S A CONSEQUENCE OF<br>rterioscler |                                |  |                  | disassa   | Year                     |                                  |
| z             | PART 2. OTHER SIGNIFICANT  | with cereb   | TING TO DEATH BUT NOT<br>ral a rterio                                  | RELATED TO                     | THE TERMINAL DISEASE COSIS, with                     | PSyc             | ion given in part 1(0)<br>hotic reaction  | n                        |                                  |
| CERTIFICATION | 190. DATE OF OPERATION   | 19b. CONDITION FOR WH  | CH OPERATION WAS PERF  | ORMED                          | 20o. AUTOPSY?  YES NO                                | <b>X</b>         | 20b. IF YES, WERE FINDINGS (<br>CAUSES OF DEATH?  | ONSIDERED IN CE          | ERTIFYING                        |
| MEDICAL CER   | 21o. ACCIDENT WAS UNDER  ☐ OR CONTRIBUTING ☐ CAUSE O  (If either, notify medicol ex          | HOUR A.M. P.M.   | Manth Doy Year<br>19   |                                |  |                  | re of injury in Port 1 or Port 2,   | Item 18.)                |                                  |
|               | at work at wark  |  | AT HOME, FARM, STREET, FACTO<br>OFFICE BUILDING, ETC.                  |                                |  |                  | City or Town  | County                   | State                            |
|               | 22a. I certify that (I)<br>saw the decease<br>causes stated ab                               | (this haspital) attended alive on attended alive on attended atten | inded the deceased<br>19<br>(did nat) view the bo                      | fram/<br>, and<br>idy after di | -19-65 , 19<br>that in (my) ( <u>aur)</u> c<br>eath. | pinian           | ta_2-16-69_, 19<br>death accurred an the do   |                          | (I) (we) las<br>and fram the     |
|               | 22b. SIGNATURE   | ayu  | lle'   | DEGRE                          | 11113.   | MED.<br>DIRECTO  | OR STAFF PHYS.  | DATE SIGNED 2-19-69      | )                                |
|               | 22d. PHYSICIAN'S<br>NAME (Type) JO   | se Chapulle  | e, M. D.   |                                | 22e. ADDRESS Sp                                      | ring<br>kesv     | field State Ho<br>ille, Maryland  | spital<br>2178           | 34                               |
|               | BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE<br>2/22/69   | 23c. NAME OF CE<br>Baltin  |                                | REMATORY<br>Cemetery                                 |                  | LOCATION (City or Town) Baltimore Ma  | (County)<br>rvland       | (Stote)                          |
|               | FUNERAL DIRECTOR<br>RAUSE FUNER  | RAL HOME   | ADDRESS<br>1216S. Ch   |                                | 2So REC'I  | RY REGI          | ISTRAR 25h REGISTRAR'S  |                          | ye:                              |



| 0 1 1   | MARYLAND STATE DEPARTMENT OF HEALTH  |   |
|---|--|---|
|   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  | 02263   |
| FOR STATE   | WEDICAL EXAMINER'S CERTIFICATE OF DEATH  |   |
| HEALTH DEPT.  | 1. DECEASED-NAME (Type or Print) John E Schmidt 20. DATE KNOWN Month Di OF ESTI- DEATH MATED Feb.  | 22 1695 45 PA                                     |
| deloy and 3 t<br>M3 Pag   | 3. SEX A FE White Fev. 23,1902 6. AGE (in years lif under 1 YEAR IF UNDER 24 HRS. Days Hours Min. Months Days Hours Min.   | Year 1969 STUL                                    |
| orm PM  | 70. BIRTHPLACE (State or foreign country) Md. CITIZEN OF WHAT COUNTRY? 8. MARRIED MEVER MARRIED 9. COUNTY OF DEATH COUNTRY) WIDOWED DIVORCED COUNTY  | oll M   |
| hours after deoth.  Iftem 18, Give Pages 1,  Office olong with form Land 2 with the State Do  |  | b. KIND OF BUSINESS OR<br>DUSTRY<br>FARMING       |
| s after 18 Give olong 2 with the death.   | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before 13c. CITY OR TOWN admission) STATE Md. 13b. COUNTY CAREO! Westminster YES NO DE BIRD VIEW   | Road  |
| 4 = 1 × ×   | 14. FATHER'S NAME First Middle Lost IS. MOTHER'S MAIDEN NAME First Middle B.   | entreus   |
| within 24<br>n pencil in<br>Exominer's<br>File pages<br>1 72 hours  | 160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na oryunknawn) (If yes give war ar dates af service) 215 16 6735 MRs. Viola Schmidt Westm   |   |
|   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  PROPERTY CAUSE (b)  PROPERTY CAUSE (b)  PROPERTY CAUSE (c)   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  2-0 |
| be executed<br>"pending" in<br>nief Medical E<br>onsit permit. F<br>event within  | Conditions, if any, which gave rise to immediate cause (a).  DUE TO, OR AS A CONSEQUENCE OF CONS | lup.  |
| s certificate should be e<br>e, writing the word "per<br>forwarded to the Chief I<br>t used as o buriol-tronsit<br>emoval, and in any even                    | stating the underlying couse DUE TO, OR AS A CONSEQUENCE OF  |   |
| ficote ring the rded to as o b  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |   |
| This certificate should cate, writing the word be forwarded to the Clebe used as a burial-transcript removal, and in any                                      | 190. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  21a. EXTERNAL CAUSE WAS 21b. TIME OF INJURY Month, Day, Year 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item  | 20. AUTOPSY? YES NO                               |
| ## F P P  | 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING Part 1 or Part 2, Item HOUR A.M. CAUSE OF DEATH P.M. 19 21d. INJURY OCCURRED 21e. PLACE OF INJURY (At hame, farm, street). 21f. LOCATION Street or R.F.D. No. City or Town   | 18.)  |
| sh fill as a short  | 21d. INJURY OCCURRED WHILE NOT WHILE AT WORK AT WORK  21e. PLACE OF INJURY (At hame, farm, street, factory, affice building, etc.)  21f. LOCATION Street or R.F.D. No.  City or Town   | Caunty State                                      |
| ICAL EXA.  s execute tor. Page ed for you CTOR: Pag   | 22o. I certify that I taok charge of the remoins described obove, held on Autopsy , Inspection , Inquiry , deoth resulted fram: Natural causes , Accident , Suicide , Homicide , Undetermined manner   | ond in my opinior                                 |
| please ey director. retained ior to bur   | ACTUAL Marriage C. Carterfield CHIEF MEDICAL EXAMINER [] 22h DATE SIG  | SNED  |
| TO DEPUTY DICAL EXAM necessory, please execute the funeral director. Page 4 5 may be retained for your TO FUNERAL DIRECTOR: Page Health prior to buriol, cren | EXAMINER'S M.C. PORTERFIEL GETTING DEPUTY MEDICAL EXAMINER DEPUTY | 2-69<br>11 Mel                                    |
| TO D  TO D  TO FU  Heol   |  | aunty) (State)                                    |
| VR A15ME (\$100 REV. 1/6)   | 24 FINERAL DIRECTOR Haight Sylephille Md, DATE FEB 2 7 1969 FINERAL SIGNERAL DATE FEB 2 7 1969 FINERAL SIGNERAL | NATURE  |
| 4   |  |   |

ADDRESS

Frederick, Marylandball

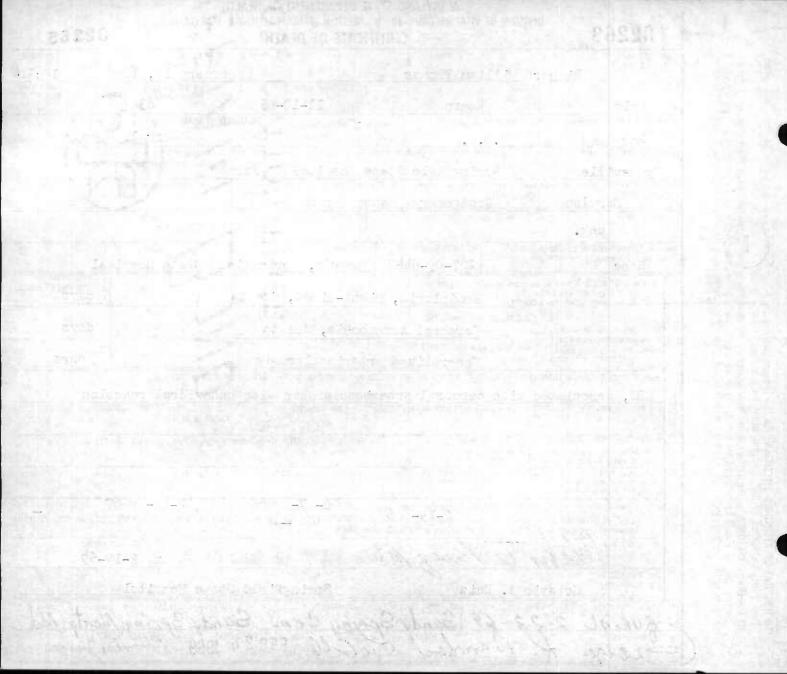
24. SUNERAL DIRECTOR

Dailev &

250 RECID BY REGISTRAR969 25b. REGISTRAR'S SIGNATURE

| TARK OF THE PARTY SALES HAVE BEEN AND THE PARTY OF THE PA |  |
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02269 CERTIFICATE OF DEATH 02265 DECEASED-NAME First Lost 2o. DATE OF DEATH signed by the attending physicion ond completely filled in by the funeral burial-tronsit permit. Then please femove corbon papers. Pages 1 and 2 burial, cremation, or removal, and in any event, within 72-bauts after death. 2b. HOUR 24 haurs after death (Type or print) Richard William Thomas February 3 SFX 4. RACE S. DATE OF BIRTH 6. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthdoy 3RS HOURS 11-10-05 Male Negro 7o. BIRTHPLACE (Stote or foreign 7b. CITIZEN OF WHAT COUNTRY? 9. COUNTY OF DEATH MARRIED X NEVER MARRIED (ountry) U.S.A. Carroll County Maryland WIDOWED [ DIVORCED [ 10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12o. USUAL OCCUPATION (Kind of work done 12b. KIND OF BUSINESS OR within give street oddress)
Springfield State Hospital during most of working life, even if retired.) INDUSTRY Sykesville 13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET AND NUMBER 76. COUNTY Montgomery Sandy Sprin 14. FATHER'S NAME First Lost 1S. MOTHER'S MAIDEN NAME First Lost unk. Liza Ella Thomas attending physicion permit. Then pleose 160. WAS DECEASED EVER IN U.S. ARMED FORCES? requires that the death certificate 16b. SOCIAL SECURITY NO. 17. INFORMANT Yes, no or unknown) (If yes give war or dates of service) 227-09-8447 Records, Springfield State Hospital 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: BETWEEN ONSET AND DEATH Hemiplegia, right-sided, due to days IMMEDIATE CAUSE (o) DUE TO. OR AS A CONSEQUENCE OF Conditions, if ony, which gove: days Cerebral thrombosis, due to rise to immediate couse (a). DUE TO, OR AS A CONSEQUENCE OF stoting the underlying couse Generalized arteriosclerosis years PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4 moy be retained by the hospital or ottending **D FUNERAL DIRECTOR:** After this certificate has been director, page 3 shauld be detached for use os the Should be filed with the State Dept. of Heolth prior to CBS, associated with cerebral arteriosclerosis with behavioral reaction OR ATTENDING PHYSICIAN: The law 19o. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20o. AUTOPSY? 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES T NO K O FUNERAL DIRECTOR: After this certificate 210. ACCIDENT WAS UNDERLYING 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) 21b. TIME OF INJURY OR CONTRIBUTING CAUSE OF DEATH HOUR A.M. Month Doy Yeor (If either, notify medical examiner) 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,) 21f. LOCATION Street or R.F.D. No. City or Town County Stote While Not while of work 22a. I certify that (I) (this haspital) ottended the deceosed from 6-29-, 1966, to 2-17-, 1907, that (I) (we last court the deceased alive an 2-19-1969, and that in (my) (our) opinion death accurred an the dote and have and from the causes stated above, (1) (we) (did) (did nat) view the bady after death. 22b. SIGNATURE 22c. DATE SIGNED MED. DIRECTOR DEGREE 2-19-59 22d. PHYSICIAN'S 22e. ADDRESS NAME (Type) Springfield State Hospital Octavio A. Ruiz 23o. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE NAME OF CEMETERY OR CREMATORY (City or Town) (County)



02270

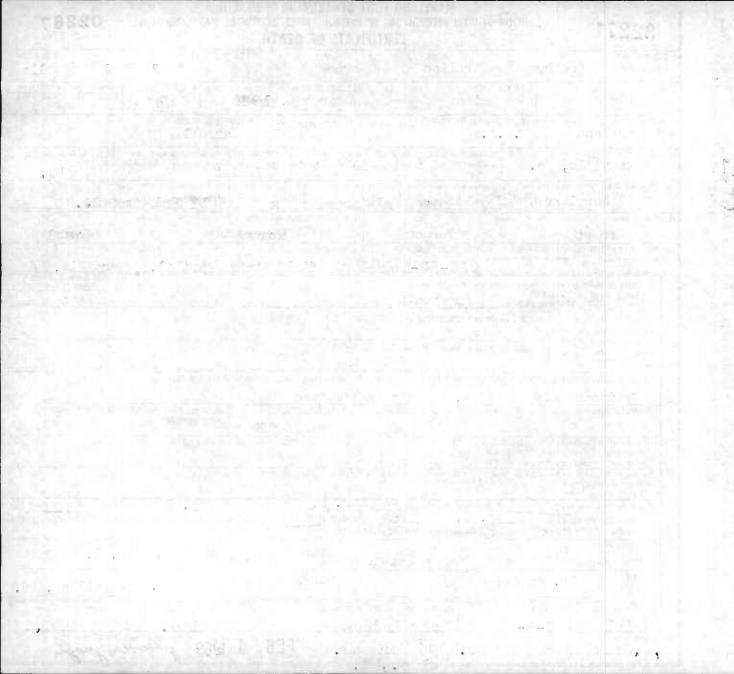
## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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|---|---|---|---|---|
|   |   |   |   |   |

| 9             | 112230   |   |  | ERTIFIC                                   | ATE OF             | DEATH                                    |                      |  | U                        | 226                   | 5                            |  |  |
|---------------|--|---|--|---|--------------------|--|----------------------|--|--------------------------|-----------------------|------------------------------|--|--|
|               | DECEASED-NAME First<br>Type or print) Wi.  | lliam                                       | Stanley Tho  | mpsbn                                     | Lost               |  | 20. DATE OF          | Month                                  | Doy                      | Yeor 69               | 2b. HOUR                     |  |  |
| 3. 9          | Male   | 4. RACE                                     | White  |   | S. DATE OF E       | 5, 191                                   | 8                    | 6. AGE (In years less birthdoy)        | YRS.                     | ONTHS DAYS            | HOURS MIN                    |  |  |
| 70.<br>cou    | BIRTHPLACE (Stote or foreign mitry) Md.  | 7b. CITIZEN OF USA                          | F WHAT COUNTRY?  | 8. MARRIED WIDOWED                        | NEVER MA           | RRIED   S                                | 9. COUNTY OF         | Carroll                                |                          |                       | Md                           |  |  |
| 10.           | CITY OR TOWN OF DEATH Westminster  | 1   | 1. NAME OF HOSPITAL OR INS   | Co. Hos                                   | spt.               |  |                      | Kind of work d<br>life, even if retire |                          | 12b. KIND OF INDUSTRY | BUSINESS OR  House           |  |  |
|               | . USUAL RESIDENCE (Where deceding in the state of the sta | sed lived, if ins<br>13b. COUN              |  | 13c. CITY OR Hampst                       | rown               | YES R NO                                 | AITS? 13e. S1        | 253 S.                                 | ain                      | St.                   |                              |  |  |
| 14.           | FATHER'S NAME First William  | S. Th                                       | le Lost<br>compson   | 15  | . MOTHER'S N       | MAIDEN NAME Fil                          | Pea                  | rl E.                                  |                          | known)                |                              |  |  |
| 160           | Yes, no, or mknown) (If yes aly  | MED FORCES?                                 | 16b. SOCIAL SECURITY I<br>212-22-286   | NO. 17. 1                                 | nformant<br>Irs. V | alerie '                                 | Thomps               | on Hamp                                | stea                     |                       |                              |  |  |
|               | 18. CAUSE OF DEATH (Enter o  |   | er line for (o), (b), ond (c). RESPIRA   |   |                    |  |                      |  |                          | BETWEEN O             | MATE INTERVAL NSET AND DEATH |  |  |
| _             | Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse lost.  PART 2. OTHER SIGNIFICANT CO   | (c)_  | OR AS A CONSEQUENCE OF  CHICONE OR AS A CONSEQUENCE OF  RIBUTING TO DEATH BUT NO |   |                    |  |                      |  | se                       | YEA                   | PRS                          |  |  |
| CERTIFICATION | 190. DATE OF OPERATION 196   | . CONDITION FOR                             | R WHICH OPERATION WAS PE   |   | 20o. AUT<br>YES 🛭  | NO 🗆                                     | CAUSE                | YES, WERE FINDING OF DEATH?            |                          |                       | RTIFYING                     |  |  |
| MEDICAL CER   | OR CONTRIBUTING CAUSE OF DEA   | iner) HOUR A                                | .M 19  | ,   |                    |  |                      | ury in Port 1 or Po                    | rt 2, Iter               | m 18.)                |                              |  |  |
| W             | While Not while of work  |   | AT HOME, FARM, STREET, FAC<br>OFFICE BUILDING, ETC.                              |   |                    |  |                      | or Town                                |                          | County                | Stote                        |  |  |
|               | 220. I certify that (1) (the saw the deceased causes stated above  | nis haspital)<br>alive on<br>e, (1) (we) (c | attended the doceose<br>lid) (did not) view the                                  | ed from<br>9 <b>7</b> , one<br>body after | d that in (r       | , 19 <u>_6</u><br><u>my</u> ) (our) opir | 4 , ta<br>nian deoth | occurred on th                         | , 19 <u>6</u><br>le dote | and hour              | (I) (we) las<br>and from the |  |  |
|               | 226 AGNATURE   | 4.1   | Erocco (   | 3 ms                                      |                    |  | ED.<br>RECTOR        | STAFF PHYS.                            | 22c. DAT                 | TE SIGNED             |                              |  |  |
| 1             | 22d. PHYSICIAN'S<br>NAME (Type)  |   | 0  |   | 22e. AD            | INKE22                                   |                      |  |                          |                       |                              |  |  |
| 230           |  | DATE <b>b. 10</b> ,                         | 1969 23c. NAME OF Grace  |   |                    |  | Upp                  | ON (City or Town)                      | i.                       | (County)              | (Stote)                      |  |  |
| 24            | FUNERAL DIRECTOR Tipton - Eline  | Funera                                      | 1 Home Hamp  | steadm                                    | Md.                | 2So. REC'D BY                            | Y REGISTRAR          | 2Sb. REGIST                            | RAR'S SIG                | GNATURE               | der                          |  |  |

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TO FUNERAL DIRECTOR: After this certificate has been director, page should be filed VR A15 (4) 30M REV. 1

PHYSICIAN'S

NAME (Type)

executed within 24 haur

PHYSICIAN: The law requires that the death certificate

physician.

be retained by the hospital or attending

signed by

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

ATTENDING

22e. ADDRESS

PHYS.

23d. LOCATION (City or Town)

DIRECTOR

(County)

(State)

PHYS.

and make a 939

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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|    |   |   |   |  | EKIIF                | LAIE UF          | DEATH               |                         |   | 022                    | 03   |            |
|----|---|---|---|--|----------------------|------------------|---------------------|-------------------------|---|------------------------|--|------------|
|    |   | no or prinel  | First<br>DNEY   | Middle<br>BENJAMIN   |                      | Lost<br>TURN     | ER                  | 2o. DATE OF             | DEATH DATE OF THE PARTY OF THE | lgy Yeor               |  | HOUR A     |
| 3  | 3. SEX  | Male  | 4. RACE<br>Negr   | ro   |                      | S. DATE OF B     | IRTH<br>08/1891     | 4                       | 6. AGE (In years<br>lost birthdoy)  | MONTHS OAY             | IF UNOER   |            |
|    | count   | RTHPLACE (Stote or foreign<br><sup>ry)</sup> Maryland   | U.S.A.  |  | WIDOWED              |                  | RCED                |                         | arroll  |                        |  | Md.        |
| 12 |   | Sykesville  | giy   | NAME OF HOSPITAL OR INS<br>e street oddress)<br>pringfield | State                | Hosp.            | during mo           | ost of working<br>Porte |   |                        | Lost CHILDS  ROXIMATE INTERVAL EEN ONSET AND DEATH days  yrs.  |            |
| 30 | 30. l<br>odmis  | JSUAL RESIDENCE (Where design) STATE Maryland   | eceosed lived, if instit  | ution: Residence before                                    | 13c. (ITY 0<br>Balt: | R TOWN           | 13d. INSIDE CITY LI |                         | REET AND NUMBER<br>7 Carey S  | treet                  |  |            |
| 4  |   | ATHER'S NAME First JOHN   | Middle  | Lost<br>TURNER   |                      | 50.5             | AIDEN NAME F        |                         | Middle  | DESC                   |  | 3          |
|    |   | WAS DECEASED EVER IN U.S<br>is, no, or unknown) (If yes   |   | 212-10-21  |                      | INFORMANT<br>Ho  | spital              | Record                  | Address   | 3i                     |  |            |
|    |   | PART I. DEATH WAS C   | AUSED BY:   |  |                      | throm            | bosis               |                         |   | APPRI<br>BETWEE        | N ONSET AND DE   | AL<br>EATH |
|    |   |   | (o),<br>(o),<br>DUE TO, OR  | Arterioscl AS A CONSEQUENCE OF                             |                      |                  |                     |                         |   |                        | yrs.   |            |
|    |   |   |   |  |                      |                  |                     |                         |   | ction                  |  |            |
| 2  | 190. DATE OF OPERATION 196. CONDITION FOR WHICH OPERATION WAS PERFORMED 200. AUTOPSY? YES NO              |   |   |  |                      |                  | OPSY?               | 20b. IF                 | YES, WERE FINDINGS  |                        | CERTIFYING   | 7          |
|    |   | 21o. ACCIDENT WAS UNDEDOTED OR CONTRIBUTING CAUSE CONTRIBUTING CAUSE CONTRIBUTION MEDICAL PROPERTY OF THE CONTRIBUTION OF THE | F DEATH HOUR A.N  | . Month Doy Yeor   |                      | IOW INJURY OC    | CURRED (Enter       | r noture of inju        | ry in Port 1 or Port 2  | 2, 1tem 18.)           |  |            |
|    | Condition rise to instanting lost.  PART 2. C BS  190. DATI  210. ACC (If either and work)  While of work | 21d. INJURY OCCURRED While Not while of work  | 21e. PLACE OF INJURY  |  |                      |                  |                     |                         |   | County                 |  |            |
|    |   | 22a. I certify that (t)<br>saw the decease<br>causes stated al  | Unknown)   (If yes give wor or dates of service)   212-10-2113   Hospital Records |  |                      | e) last<br>m the |                     |                         |   |                        |  |            |
|    |   | 22b. SIGNATURE  | Suha O  | miles.   | DEG                  | REE PHYS.        | U D                 | MED.                    | STAFF PHYS.   | c. DATE SIGNED 2/24/69 |  |            |
| 1  |   |   | uha Ozgun   |  |                      |                  |                     |                         | 8 Hospita   |                        |  |            |
| 列  |   | REMOVAL (Specify)   | 23b. DATE<br>2/2 <b>7</b> /69   |  | calv                 | ary              |                     | Balti                   | ON (City or Town) LMORE, M  |                        |  | )          |
| 4) | 24. F   | uneral director<br>charles R.   | Law, 80   | )2 , Madiso  | on Av                | re.              | 2So. REC'D B        |                         | 25b. REGISTRAR  | es SIGNATURE           | TOOM  IF UNDER 24 HES. HOURS MIN.  Md. F BUSINESS OR  Lost HILDS  XIMATE INTERVAL ONSET AND DEATH days  Yrs.  CERTIFYING  Stote at (I)x (we) last r and fram the |            |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after deoth.

Page 4 moy be retained by the hospital or ottending physician.

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| , versus designations | 7 7.3 [8]      | 1,41   |                 |         |       |
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| 1 4  |               | MARYLAND STATE DEPARTMENT OF HEALTH  DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |
|--|---------------|--|--|
| FOR STATE  |               | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  | 02270  |
| HEALTH DEPT.   |               | ECEASED-NAME First Middle Lost 2a, DATE KNOWN Month  | Day Year 2b, HOUR                            |
| à 5 € 5 × 5  | (             | Type or Print)  LILLIE RITH WELLS DEATH MATED THE PLANT AND THE PLANT PRINTS OF ESTI-  | 1 1969 1240/7                                |
| Pag tent of  | 3. S          | 4. RACE 5. DATE OF BIRTH 6. AGE (In years   IF UNDER 14 HRS. 2c. DATE PRONOUNCED DEAD  | 2d. HOUR                                     |
| y delice on the part of the pa | -             | Negro 7-5-24 hh yrs.   | Yeor 19 691278 N                             |
| 1, 2<br>m<br>Dep   |               | BIRTHPLACE (Stote or foreign 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED NEVER MARRIED 9. COUNTY OF DEATH  |  |
| far<br>far<br>ate  | St            | Duth Carolina U.S.A. WIDOWED DIVORCED Carroll  TITY OR TOWN OF DEATH 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 12a. USUAL OCCUPATION (Kind of work done        | M-   |
| Haurs after death. Only term 18. Give Pages 1, 2, Office along with farm Pand with the State Department death.   | 2             | give street address) during most of working life even if retired   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Give<br>Give<br>Ing<br>h th  | -             | USUAL RESIDENCE (Where deceosed lived, if institution: Residence before 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET AND NUMBER                                    |  |
| s after 18. Give allang death.   |               | dmission) STATE Waryland Baltimore City Baltimore YES X NO 753 Lake Drive  | 9  |
| haurs haurs Offfice Office   | 14. F         | ATHER'S NAME First Middle Lost 1S. MOTHER'S MAIDEN NAME First Middle   | Last   |
| 5. C. C. S   |               | Early Summers Bertha   | Jones  |
| thin 24 incil in niner's pages hours   | 160.          | WAS DECEASED EVER IN U.S. ARMED FORCES?  16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS  | 001103                                       |
| d within<br>in pencil<br>Examine<br>File pagon   | N             | (es, no, or unknown) (If yes give war or dates of service) 251-22-6055 Records, Springfield State Hospit   | tal  |
| nauld be executed within 2<br>ward "pending" in pencil j<br>the Chief Medical Examiner<br>rial-transit permit. File page<br>n any event within 72 hour   |               | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| e execute<br>pending"<br>of Medica<br>sit permit   |               | IMMEDIATE CAUSE (o) ASphuxia.  | mins.  |
| e e e e f V e f V e n sit  |               | Conditions, if ony, which gove rise to immediate couse (a).  DUE TO, OR AS A CONSCIUENCE OF OCCIUSION of larynx of base of tongue  (b) probably during a convulsive seizure. | mins.  |
| Ild burd 'Chi  |               | rise to immediate couse (a), (b) probably during a convussive serzure.  DUE TO, OR AS A CONSEQUENCE OF   | MILIIS.                                      |
| e shauld be executed<br>the ward "pending" ir<br>ta the Chief Medical<br>1 burial-transit permit.<br>1d in any event within  |               | lost.  |  |
| 0 = -  | 1,11          | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |
| vertificat<br>writing<br>rwarded<br>ised as a  | NO            | Schizophrenic reaction, catatonic type. Convulsive disorder.   |  |
| his certificate, writing farward be used a r remaval,  | ICAT          | 190. DATE OF OPERATION 196. CONDITION FOR WHICH OPERATION WAS PERFORMED?   | 20. AUTOPSY?                                 |
| be est   | CERTIFICATION | 21a. EXTERNAL CAUSE WAS 21b. TIME OF INJURY Manth, Day, Year 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Iter                                      | YES X NO                                     |
|  | MEDICAL       | PRIMARY OR CONTRIBUTING HOUR A.M.  P.M. 19   | 11 10.)                                      |
| S E E  | MED           | 21d. INJURY OCCURRED 21e. PLACE OF INJURY (At home, form, street, 21f. LOCATION Street or R.F.D. No. City or Town  | County Stote                                 |
| DEPUTY SICAL EXAMINER: Sessary, please execute the certile funeral director. Page 4 shauld may be retained far yaur files. FUNERAL DIRECTOR: Page 3 shauld priar to burial, cremation,   |               | WHILE NOT WHILE factory, office building, etc.)  |  |
| ICAL EXA execute for. Page ed far yau CTOR: Pag burial, cre  |               | 22a. I certify that I taak charge af the remains described abave, held an Autapsy 🖳 Inspection 🔲, Inquiry 🔲  | , and in my apinian                          |
| SICA<br>cror.<br>cror.<br>ned<br>ECTC  | - 1           | death resulted fram: Natural causes 🗌 , Accident 🔲 , Suicide 🔲 , Hamicide 🔲 , Undetermined manner [  |  |
| please e<br>please e<br>I director<br>retained<br>DIRECT<br>ar ta bu   |               | ACTUAL MOLICE C CRAFTER POLICE EXAMINER -  |  |
| ITY, ple<br>eral di<br>be retu<br>RAL DI<br>priar  | 13            | SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER 22D. DATE S  | IGNED 169                                    |
| O DEPUTY necessary, p the funeral 5 may be r O FUNERAL Health prior  |               | EXAMINER'S M.C. PORTERFIE IN M.D DEPUTY MEDICAL EXAMINER & 2/ ADDRESS (Street, city, town, or couply) AM DST   | excl wat                                     |
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